LEVEL OF DEPRESSION AND COPING STRATEGIES AMONG HIV CLIENTS

DISSERTATION SUBMITTED TO

THE TAMIL NADU DR. M.G.R. MEDICAL UNIVERSITY CHENNAI

in Partial Fulfilment of requirement for the award of

DEGREE OF
MASTER OF SCIENCE IN NURSING

APRIL, 2011

A STUDY TO ASSESS THE LEVEL OF DEPRESSION AND COPING STRATEGIES AMONG HIV CLIENTS IN SELECTED SETTING, SINGAPERUMAL KOIL, 2010 – 2011.

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- **K. KALAISELVI.**

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ABSTRACT

AIDS, the acquired immune – deficiency syndrome (sometimes called "Slim Disease") is a newly described, usual fatal illness caused by a retrovirus known as the Human Immuno Deficiency Virus (HIV) which breaks down the body's immune system, leaving the victim vulnerable, to a host of life-threatening opportunistic infectious, neurological disorders or unusual malignancies among the special feature of HIV infection is that a person once infected will be infected for life. Strictly speaking, the term AIDS refers only to the last stage of HIV infection. AIDS can be called our modern pandemic, affecting both industrialized and developing countries.

A number of social conflicts such as fear of exposure of diagnosis and being a member of a stigmatized group are commonly experienced by people who have HIV. Crisis Points – Several Crisis Points occur during the course of HIV disease. The diagnosis of HIV may be first crisis with the initial diagnosis the person often feels intense anxiety, fear, anger and guilt and may act impulsively. High levels of anxiety and depression may continue for 2-3 months and may be exhibited in agitation, risky sexual behavior, crying and suicidal ideation and attempts. In fact symptoms of depression and anxiety may overlap with HIV symptoms complicating diagnostic and treatment efforts.

The National AIDS Control Organization of India (NACO) estimates the number of people within India as 5-1 million in 2004. India has the second highest number of people living with HIV/AIDS with the world after South Africa. India Accounts for almost to persons of the million people living with HIV/AIDS globally.

The objectives of the study was to assess level of depression and coping strategies among HIV Clients. A descriptive Research design was adopted for this study. The study was conducted in We Care Social Service Society, Singaperumal among 100 clients. The data was collected from HIV Clients who fulfilled the inclusion criteria by using Beck's depression Inventory and Lazarus coping Inventory. The Interview was conducted in Tamil. Ethical aspects were considered throughout the study. The conceptual framework adopted for this study was modified Pender's Health Promotion Model.

The study findings revealed that among 100 HIV Client, 11% of HIV clients had mild depression, 15% of HIV Clients had sever depression and 74% of HIV clients had moderated depression. It also revealed that 3% of HIV Clients had inadequate coping, 7% of HIV Clients had adequate coping and 90% of HIV Clients had moderately adequate coping.

The Psychiatry Nurse, as a Nurse Educator should aim at reorienting general education system and professional curriculum to suitably incorporate the preventive measures and management strategies regarding HIV. As a Psychiatric Nurse the investigator has provided information to the entire subjects about HIV and method to overcome the problems.

CHAPTER I

INTRODUCTION

"Tis harder knowing it is due
Than knowing it is here
The trying on the utmost
The morning it is new
Is terribler than wearing it
A whole existence through.

- Emily Dickinson,

While we were fearing it, it came"

AIDS, the acquired immune – deficiency syndrome (sometimes called "Slim Disease") is a newly described, usually fatal illness caused by a retrovirus known as the Human Immuno Deficiency Virus (HIV) which breaks down the body's immune system, leaving the victim vulnerable, to a host of life – threatening opportunistic infections, neurological disorders, or unusual malignancies – Among the special feature of HIV infection is that a person once infected will be infected for life. Strictly speaking, the term AIDS refers only to the last stage of HIV infection. AIDS can be called our modern pandemic, affecting both industrialized and developing countries.

Background of the Study :

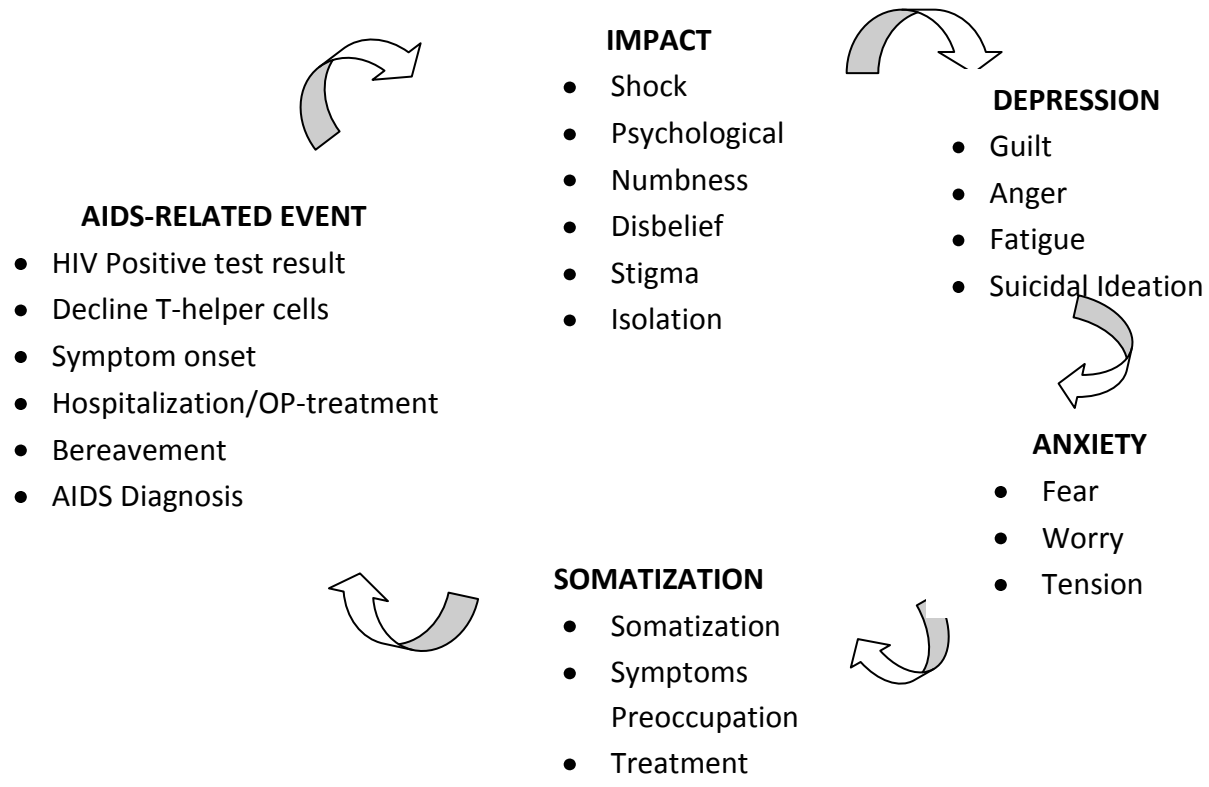
HIV/AIDS is one of the greatest challenges facing the world today. This courage of AIDS poses grave economic as well as social and health challenges.

HIV / AIDS is one of the most devastating global epidemics of the 20^{th} century. The Human Immuno Deficiency Virus (HIV) and the resulting acquired Immuno Deficiency Syndrome (AIDS) include a variety of serious disorders such as opportunity infectious resulting from a compromised Immuno System and significant co-occuring psychiatric illnesses. Care of patients with HIV/AIDS and their families, friends and community involves the physical psychological, emotional and social aspects of people's lives from a variety of different population groups.

When individuals are informed that they are tested positive for HIV Antibodies, they confront the realization that they have contracted a terminal illness. The realization can be accompanied by profound feelings of shock, denial, disbelief, loneliness, hopelessness, guilt, grief, fear and anger. The person may exhibit poor sleep and appetite, increased alcoholic intake, suicide, write will and feel relieved that the cause of symptoms is found.

Many Psychiatric Syndrome are associated with HIV/AIDS Depression, anxiety, paranoia, mania, irritability, psychosis and substance are common in HIV positive persons. Complicate immune System function, adversely affect the patient's ability to fully participate in treatment and negatively impact on quality of life. A thorough Psychiatric history and complete neuro-psychiatric evaluation are indicated when HIV Positive patients present with Psychiatric Symptoms.

Cycle of reaction to HIV Disease



A number of social conflicts such as fear of exposure of diagnosis and being a member of a stigmatized group are commonly experienced by people who have HIV. Crisis Points – Several Crisis points occur during the course of HIV disease. The diagnosis of HIV may be first crisis. With the initial diagnosis the person often feels intense anxiety, fear, anger and guilt and may act impulsively. High levels of anxiety and depression may continue for 2-3 months and may be exhibited in agitation, risky sexual behavior, crying and suicidal ideation and attempts. In fact symptoms of depression and anxiety may overlap with HIV Symptoms complicating diagnostic and treatment efforts.

It has been well documented that the immune system is compromised in people with high levels of stress and with depression. In people with HIV depression can confuse diagnostic and treatment issues of both illness because of the overlap between the vegetative symptoms of HIV and the neuro-physiological symptoms of depression. Depression is thought to be one of the most common psychiatric disorders in HIV infected people, and is a potentially dangerous comorbid condition because it may hasten the course of HIV disease. It has been shown that there is a dramatic sustained rise in depressive symptoms as AIDS develops, beginning as early as 18 months before clinical AIDS is diagnosed and that approximately 40% of hospitalized patients with HIV have clinical depression.

Patients with HIV disease who are depressed experience the emotional pain and suffering common to depression, including depressed mood and decreased motivation, lowered self esteem, guilt, increased isolation, lowered energy level, sleep disturbance change in appetite, somatic complaints, increased sense of helplessness, increased risk for suicide stigma in addition to the problems of having HIV.

SIGNIFICANCE AND NEED FOR THE STUDY

The first serological evidence of HIV infection in India was discovered among female sex workers in Tamil Nadu in 1986. Since them, studies conducted all over India have shown that the infection is prevalent in a number of population groups as well as locations. Today HIV has been detected in 29 of India's 32 states and territories.

The National AIDS control Organization of India (NACO) estimates the number of people within India as 5-1 million in 2004. India has the second highest number of people living with HIV/AIDS in the world after South Africa. India accounts for almost 10 persons of the million people living with HIV/AIDS globally and over 16% of the 7.4 million people living with HIV/AIDS in the Asia and Pacific region.

Researchers studying the prevalence of Psychiatric disorders among HIV positive patients have found a 57.3% prevalence of depression among HIV infected patient and a 69.8% prevalence of depression among people co-infected with HIV and Hepatitis C.

A National survey indicates that its fairly common for HIV Physicians to identify depression and similar symptoms in HIV infected patients. A telephone survey of AIDS Physicians found that 84.3 percent reported that their HIV Positive patient suffered from depressive symptoms.

Baseline data on depression was gathered from various groups and communities interviewed by Thranitran. A total number of 75 responses were collected using Beck's Depression, Inventory and analyzed. It was interesting to note that only 32% of the population falls within normal variation limits. 17% reported mild depression, 11% had baseline clinical depression 23% had moderate depression and 17% of the randomly selected subjects were round to have sever (or) extreme depression atleast at cognitive level.

TITLE :

To assess the level of depression and coping strategies among HIV Clients.

STATEMENT OF THE PROBLEM

A study to assess the level of depression and coping strategies among HIV Clients in selected setting.

OBJECTIVES

1. To asses the level of depression among HIV infected clients.
2. To determine the coping strategies of clients with HIV Infection.

3. To correlate the level of depression and coping strategies among the HIV clients
4. To associate the demographic variables with the level of depression
5. To associate the demographic variables with the level of coping

NULL HYPOTHESIS

Ho1- There is no significant relationship between the Level of Depression and the Level of Coping Strategies among HIV Clients.

VARIABLES

Research Variables :

Depression and coping strategies regarding problems related to HIV Clients.

Demographic Variables:

Age, Sex, Religion, Education, Occupation, Income, Availability of Support System, No. of Children, Marital Status, Duration of Illness.

ASSUMPTIONS

1. The HIV infected clients my have different levels of depression according to the symptoms.
2. The demographic data may influence the depressive level of the HIV clients.
3. Client may have poor coping strategies.

OPERATIONAL DEFINITIONS

Level of depression :

It is a pathological mood disturbance characterized by feelings, attitudes and beliefs the person has about self and his environment as measured by Beck's Depression Inventory. For the purpose of the study depression was classified as normal, mild depression, borderline clinical depression, moderate depression, severe depression and extreme depression.

HIV infected patients

Refers to patients who were diagnosed to suffer from Human Immuno Deficiency Virus Infection

Coping Strategies

Is refers to the specific efforts, both behavioural and Psychological, that people employ to master, tolerate, reduce, or minimize the stressful events. Main three classification of coping strategies are action coping, cognitive coping and symptom direct coping.

DELIMITATIONS

- The study is delimited to a period of 4 weeks.
- The study is delimited to selected settings.

PROJECT OUTCOME

1. The identification of depression and knowledge regarding HIV Clients will help the nurse to take meticulous actions in advance, which will prevent HIV.
2. The findings would provide an insight regarding areas where the patients lack knowledge on HIV and this finding can help to plan for many education programmes and prevent hazardous of HIV.

SUMMARY

This chapter contains background of the study, significance and need for the study, title, statement of the problem, objectives, variables of the study, assumptions, operational definitions, delimitations and projected outcomes.

ORGANISATION OF THE REPORT

The following chapter contains

CHAPTER-I **:** Introduction, background, significance and need for the study

CHAPTER-II **:** Review of literature and conceptual framework

CHAPTER-III **:** Methodology

CHAPTER-IV **:** Analysis and interpretation of data

CHAPTER-V **:** Discussion

CHAPTER-VI **:** Summary and recommendations

This is followed by references and appendices

CHAPTER-II

REVIEW OF LITERATURE

The review of Literature is essential to all steps of the research process. This prospective, review is based on broad, systematic and critical collections and evaluation of the important published scholarly literature and unpublished research finding. Reading the literature is to develop sound studies that contribute to development of knowledge in the aspect of theory, research, education and practice.

Review of Literature is a critical summary of research on a topic of interest, often prepared to put a research problem in context or as the basic for an implementation project (Polit and Hungler, 2002).

Review of Literature was done for the present study and presented in the following headings.

Part-I : Review of Literature

Section A : studies related to depression in general.

Section B : studies related to depression among HIV infected patients.

Section C : Studies related to coping among HIV infected patients.

Part-II :

Conceptual Framework.

PART-I

Section A : Study related to Depression in General :

Chou KL, Chi J, (2005) conducted a study among 318 Hong Kong Chinese elderly Pts. Major variables used were pain, depression, social support, functional disability, and social functioning. The tools used was MDSHC Multiple regression analysis was used. Pain at baseline significantly predicted depression at 12 months follow-up assessment, when age, gender, marital status, education and depression at baseline was not associated pain at 12 months after a baseline measured. Depression did predict the onset of pain.

HO PM, et al; (2005) conducted a coherent study among 648 patients undergoing valve surgery at 14 veteran administration hospitals. Major variables in the study were conducted the following cardiac valve surgery to measure depression mental health inventory was used. Type of statistics used was multi variable logistic regression. Overall 29.2 percent (189/648) of the patients were depressed at baseline. Depressed patients were younger more frequently New York Hear Association Class III/IV Symptoms & more likely required emergent surgery, pre-operative intravenous nitroglycerine or intra aortic balloon pump. Unadjusted 6 month mortality was 13.2 percent for depressed patients compared with 7-6 percent for non depressed patients.

Nanthini-k, Iyer 9, (2004) conducted a study, among 100 (32 females, 68 males) voluntarily retired employees of textile mills in Coimbatore. Among the 32 female respondents 29.38 percent have minor depression. 25 percent have major depression and 15.63 percent have no depression. Sampling was done using snow ball technique.

Mui (2001) studied among 67 elderly Korean immigrants. The purpose was to assess stress, coping and depression. Major variables used were life stresses, social support & depressive symptoms. Those who reported poorer health, who had more stressful life events, who were dissatisfied with the help received from family members and reported few good friends were more likely to be depressed than those who did not.

Section B : Studies related to Depression among the HIV Infected Patients

Judith A Cook et al; (2004) conducted a study among 1716 HIV zero positive woman to examine association between depressive symptoms and AIDS related mortality. The variables used were depressive symptoms & AIDS related mortality. The tool used was centre for epidemiologic studies depression scale, multivariate cor and logistic regression analysis. AIDS related death were more likely with chronic depressive symptoms, & symptoms were more severe among women in the terminal phase of their illness, mental health service was associated with reduced mortality.

Komiti A, Judd F, et. al; (2003) conducted a study among 322 persons living with HIV/AIDS to gain an estimate of the rate of depressive disorders in patients with HIV/AIDS attending general practice and to investigate factors associated with depression. The tool used was Inventory to Diagnose Depression. 22 percent of the sample met criteria for a current major depressive episode on the IDD. The study concluded that there was a high rate of self reported depression of people living with HIV/AIDS was also recognized by treating clinicians.

Sambamoorthi U, et al (2000) conducted a study on HIV infected Medicaid patients diagnosed with depression. The variables used were anti depressant treatment, health service utilization, depression and logistic regression & ordinary least squares regressions were used. Women were more likely and African American were less likely to be diagnosed with depression. Women and drug users in treatment were more likely to receive anti-depressive treatment.

Valente SM, Samders JM, (1997) conducted a study on managing depression among people with HIV disease. They conducted that many people with HIV suffer from depression, with responds to antidepressants, counseling, education and cognitive strategies. Untreated depression hinders treatment compliance & increases the risk of suicide. Management of 8 complications of major depression are described. The evaluation of rational suicide is examined. Clinicians who treat this population need to respond therapeutically to patients with depression and suicidal ideas.

Judd F, et, al; (1999) conducted a study among 192 patients with HIV infection. Variable used was depression symptoms. Beck's Depression Inventory was used, 95 scored 7 greater than or equal to 14 on the BDI & 1/3rd of these were found to have depressive disorders and the depressive symptoms are common among patients with HIV infection.

Judd FR & Mijeli AM, (1996) conducted a study on depressive symptoms among 100 HIV Positive patients, attending the OP Clinic at fair field Hospital, Melbourne, 44 patients scored 14 or more on the Bech's Depression Inventory. No significant relationship was demonstrated between the BDI score and the living situation. In the Counters for Disease Control (CDC) category of illness, there were significantly more patients scoring in the depressed range who were unable to work because of illness. 40 patients reported Depressive Symptoms and suicidal ideation were commonest among the HIV positive patients at greater rates than the medically ill population.

Balfour L, (2006) conducted a study on improving psychological readiness for successful HIV medication adherence and reducing depression before initiating HAART in USA sixty-three HIV-positive patients not currently on antiretroviral therapy participated in a randomized controlled trial of a standardized four-session psycho-educational intervention. Among 27 depressed patients, 15 those receiving the intervention reported significantly lower mean depression scores at four-weeks.

Linn JG, (1996) conducted a study on self-appraised health, HIV infection, and depression in female clients of AIDS counseling centres in USA. Data were obtained from 103 HIV –infected women who sought support, counseling, and maintenance services from one of four HIV care and referral centers in the mid-south. The results emphasize that perceived health status may fulfill a psychological distress-moderating or distress-aggravating function for women with HIV/AIDS.

Linn JG, (1996), conducted a study on perceived health, HIV illness, and mental distress in African- American Clients of AIDS counseling centers in USA Data were obtained from 255 HIV-infected black adults who sought support counseling, and maintenance services from one of three HIV care and referral centers in the mid-south.

The results emphasized that perceived health status may fulfill a psychological distress moderating or distress- aggravating function for persons with HIV /AIDS.

Fukunishie I, (1997), conducted a study on Avoidance coping behaviors and low social support are related to depressive symptoms in HIV- positive patients in Japan. The authors examined the influences of several psychosocial factors on mood status in 47 human immunodeficiency virus positive patients without the acquired Immuno Deficiency Syndrome. The results suggest that, the depressive symptoms are not strong enough to warrant a psychiatric diagnosis.

Weimer E, (1991) conducted a study on Depressive reactions and psychological processing of HIV-positive homosexual males in Heidelberg. Present study examined in 54 HIV –positive male homosexuals not suffering from AIDS, the causes of the depressive management by comparing a depressive and a non-depressive group. The results show that three well-defined styles of coping can be discerned, namely , self-confrontation, avoidance, and seeking social support.

Siegel LC (2005),conducted a study on stress-related growth among women living with HIV/AIDS in USA. Examined among 138 women living with HIV/AIDS. Most women reported high levels of growth. Multivariate analyses revealed that positive reappraisal coping . These findings suggest that the stress-related growth is more than positive reappraisal and the absence of negative affect, and that social resources may facilitate greater growth.

Leserman J, (2000), conducted a study on impact of stressful life events, depression, socialsupport, coping, and cortisol on progression to AIDS in USA. Studied n=82 homosexual men with HIV type-1 infection without Aids. Cox regression models with time –dependent covariates were used adjusting for race, baseline CD4(+) count and viral load and cumulative average antiretro viral medications.

Mello VA, (2006) , conducted a study on Depression in women infected with HIV in Brazil. studied n=120 women 60 symptomatic (with AIDS symptoms) and 60 asymptomatic (without AIDS symptoms). The prevalence of major depression was 25.8% and was higher in the symptomatic group than in the asymptomatic group.

Ross R, (2009), conducted a study on Depressive Symptoms among HIV-positive pregnant women in Thailand. Author studied n = 127 HIV –positive pregnant

women. 78% of the 127 participants reported depressive symptoms to some degree. Physical symptoms were positively associated with depressive symptoms, but self-esteem, emotional support, and financial status were negatively correlated with this.

Lee SJ, (2007), conducted a study on depression and social support among HIV-affected adolescents in Duan. Underscore the complex relationships between social support and mental/ behavioral outcomes among HIV-affected adolescents as well as the need to examine HIV disclosure in more detail within the context of adolescent social support.

Olisah, Vo (2010),conducted a study on adherence to highly active retroviral therapy in depressed patients with HIV/AIDS attending in Nigeria. A total of 310 patients with HIV /AIDS receiving HAART participated in the study. 68.4% were female and the mean age was 35.5% & 37.4% had secondary education, while 27.1% had tertiary education.

Akna DH. (2010), conducted a study on A comparison of the clinical features of depression in HIV-positive and HIV- negative patients in Uganda. Study was carried out on 64 HIV- positive depressed and 66 HIV-negative patients when HIV- positive patients were more likely to be widowed.

Section C : STUDIES RELATED TO COPING AMONG HIV INFECTED PATIENTS:

Griswold GA (2005) conducted a study on coping strategies of HIV patients with peripheral neuropathy in USA with 78 HIV seropositive subjects. These results demonstrate that coping strategies may differ according to age, gender, and ethnic background in and HIV population.

Olley BO, (2003), conducted a study on psychopathology and coping in recently diagnosed HIV/AIDS patients. The role of gender in Typerberg with 149 patients with HIV/AIDS. 56% of patients were diagnosed with a psychiatric disorder, 34.9% had major depression 21.5% dysthymic disorder 14.8% post traumatic stress disorders and 10.1% alcohol dependence.

Sikkema KJ, (2003) , conducted a study on AIDS-related grief and coping with loss among HIV-positive men and women is USA with a sample of 268 HIV-infected individuals. Interventions are needed to enhance coping and reduce psychological distress associated with the unique bereavement experienced by people living with HIV- and AIDS –related grief.

Sigel LC (1997), conducted a study coping and mood in HIV- positive women in Newyork with a sample of 145 HIV –positive women. These findings are consistent with those previously reported for HIV-positive men, suggesting that similar kinds of coping strategies may be associated with positive men, and also the similar kinds of coping strategies may be associated with positive and negative moods among HIV-positive men and women/.

Krikorian R, (1995), conducted a study on emotional distress, coping, and adjustment in Human Immuno Dvirus infection and Acquired Immune Deficiency Syndrome in ohio. With 57 ambulatory, human immunodeficiency virus infected patients. The findings suggest both HIV sero positive status and perceived risk for infection produced a sustained level of generalized psychological distress.

PART-II

CONCEPTUAL FRAME WORK

A conceptual framework or a model is made up of concepts, which are the mental images of the phenomenon. It offers framework of prepositions for conducting research. These concepts are linked together to express the relationship between them. A model is used to denote symbolic representation of the concepts.

A conceptual framework is interrelated concepts on abstractions that are assembled together in some national scheme by virtue of their relevance, to a common theme. It is a device that helps to stimulate research and the extension of knowledge by providing both direction and implication (Polit and Hungler, 1995).

This section deals with conceptual framework adopted for the study. A conceptual framework or model provides the investigator the guidelines to proceed in attaining the objectives of the study based on a theory. It is a schematic representation of the steps, activities and outcomes of the study.

Modified Pender's Health Promotion Model (1987)

The Modified Pender's Health Promotion Model is adopted to this study. This model seeks to increase the individual's level of well-being. The model focuses on modifying factors, cognitive factors and likelihood of participation in health promotion behavior.

This model is used to predict likelihood of person engaging in health promoting behaviours. The cognitive factors reflect on individual's being, additional modifying factors influencing the way a person perceived the benefits and barriers of health action, which influence the person's likelihood of action.

As the investigator aimed at assessing the depression and Coping Strategies among HIV infected clients, the Pender's Health Promotion Model was found suitable to assess the depression of HIV Clients and their Coping Strategies.

Modifying Factors

Individual perception about depression and coping strategies on HIV Clients by modifying factors like demographic factors such as age, sex, religion, educational status, occupation, Income, children, marital status, duration of illness, availability of support system.

Cognitive Factors

It includes the level of depression and Coping Strategies. It depends on individual factors. It can be either mild depression and a adequate coping or severe depression or inadequate coping which motivates the clients to take or prefer an action to overcome their existing problem.

Likelihood of Action

The likelyhood of action of this study is the outcome of the forces of modifying factor and cognitive factor result in the health outcome in terms of satisfied and a healthy life or unsatisfied and unhealthy life.

On this model, the investigator interacts with the subject to assess the depression and Coping strategies on HIV Clients. The outcome of this could be mild and severe depression and adequate and coping. Those with mild depression and adequate coping enhance the likelihood of action this will promote optimum healthy life by compliance.

On the other hand, those who have severe depression and inadequate coping on HIV results in poor likelihood which will add to unhealthy life by non-compliance, at this juncture, the nurse provides pamphlet and incidental health teaching to enhance compliance, promote an optimum healthy and a satisfied life.

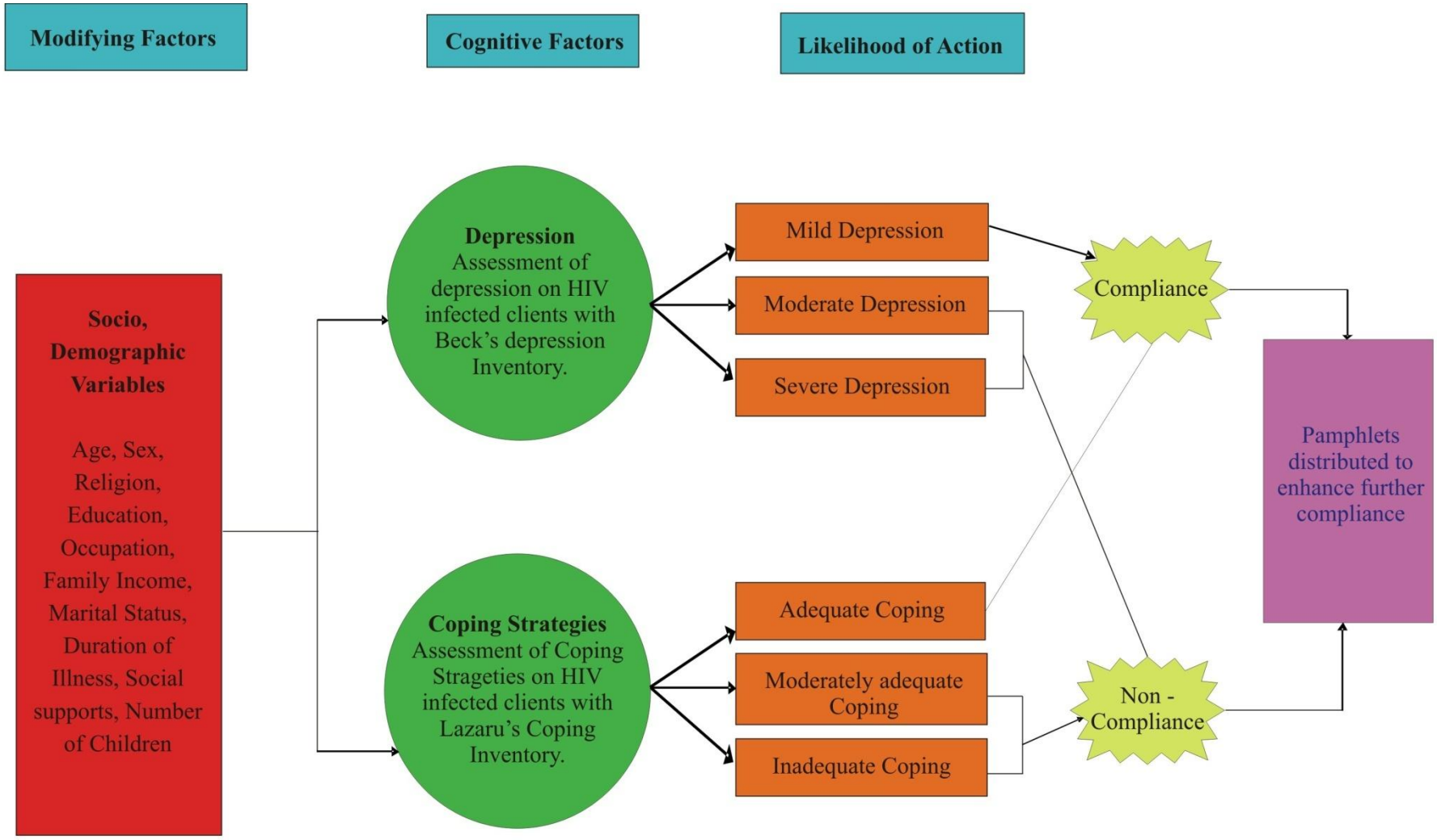


FIG.1: MODIFIED PENDERS HEALTH PROMOTION MODEL (1987)

CHAPTER-III

RESEARCH METHODOLOGY

According to Polit and Beck (2004) Research Methods are the techniques used by researchers to structure a study and to gather and analyse information relevant to research question.

This chapter deals with the description of Methodology and the various steps adopted to collect and organize data for the study. Research Methodology involves the systematic procedure by which the investigator starts from the initial identification of the problem to its final conclusion. Methodology is a significance part of any study which enables the researcher to project the research undertaken.

The methodology section includes the research approach, research design, variables, setting of the study, population, sample and sample size, sampling technique, sampling criteria, development of the tool, description of the tool, content validity, reliability, pilot study, data collection procedure and plan for data analysis.

RESEARCH APPROACH

The research approach used by the investigator to assess level of depression and coping strategies was descriptive approach.

RESEARCH DESIGN

According to Polit and Beck (2004) the research design is the over all plan for obtaining answers to the questions being studied and for handling some of the difficulties encountered during the research process.

The research design selected for this study is **Non Experimental** Research Design.

VARIABLES UNDER STUDY:

Research Variables :

Depression and Coping Strategies regarding problems related to HIV.

Demographic Variables :

Age, Sex, Religion, Education, Occupation, Income, Availability of Support System, No. of Children, Marital Status, Duration of Illness about HIV.

RESEARCH SETTING :

According to Polit and Beck's (2004) Setting is more specific places whose data collection occurs. The selection of setting was done on the basis of feasibility of conduction the study, availability of subjects and cooperation of authority. For the study, WE CARE SOCIAL SERVICE SOCIETY, Singaperumal Koil was chosen considering the availability of samples, acquaintance of the investigator with the area and the co-operation from the institution.

POPULATION :

Population refers to the entire set of individuals having some common characteristics and it is important to make distinction between target and accessible population.

Target Population

Target Population of the study comprised of all HIV Clients.

Accessible Population

Accessible Population of the study comprised of HIV Clients who are at We Care Social Service Society.

SAMPLE

Sample is a subset of the population selected to participate in a research study sampling refers to the process of selecting a portion of a population to represent the entire population (Polit and Hungler 1999).

The sample of the study comprised of all HIV Clients at We Care Social Service Society who fulfilled the inclusion criteria.

SAMPLE SIZE

The Sample Size consists of 100 HIV Clients at We Care Social Service Society who fulfilled the inclusion criteria.

SAMPLING TECHNIQUE

Sampling Technique refers to the process of selecting the population to represent the entire population. The Sampling Technique employed in this study was purposive sampling technique. According to the investigators convenience, the HIV clients who are at We Care Social Service Society and who fulfilled the inclusion criteria were selected as samples.

CRITERIA FOR SAMPLE SELECTION

Inclusion Criteria :

1. Diagnosed to be HIV infected.
2. HIV infected patients present in WE CARE SOCIAL SERVICE SOCIETY at the time of data collection.
3. Those who were able to read (or) write Tamil.

Exclusion Criteria

1. Clients who refused to participate in the study.
2. HIV infected individuals within 60 Yrs. of age.
3. Clients who suffered from acute or chronic illness.
4. Clients with hearing problem as reported by them.

METHOD OF DEVELOPING THE QUESTIONNAIRE

The following steps were carried out in developing Questionnaire.

1. Literature Review
2. Expert Opinion

Literature Review

Literature from books, journals, periodicals, published studies and newspaper articles were reviewed and develop the tool.

Expert Opinion

The investigator had discussed with the experts and incorporated their valuable suggestions in developing the tool.

DESCRIPTION OF THE RESEARCH TOOL :

After an extensive review of Literature, discussion with experts and the investigator's personal experience, two types of tools were developed to collect the data.

1. Beck's depression inventory to assess the depression on HIV Clients.
2. Lazarus coping inventory to assess the coping strategies on HIV Clients.

Format of the structured questionnaire includes,

Section A : Consists of demographic variables.

Section B : Consists of Beck's Depression Inventory to assess the depression regarding problems related to HIV clients.

Section C : Lazarus Coping Inventory to access the coping strategies regarding problems related to HIV Clients.

Section A:

Social Demographic variables include Age, Sex, Religion, Education, Occupation, Income, Availability of Support System, No. of Children, Marital Status, Duration of Illness about HIV Clients.

Section B :

Beck's Depression Inventory (Aaron.T.Beck)

The Beck's Depression Inventory is a 30 item test presented in multiple choice format which purports to measure presence and degree of depression in adolescence and adults. Each of the 30 items of the Beck's Depression Inventory attempts to assess a specific symptom or attitude which appear(s) to be specific to depressed patients, and which are consistent with descriptions of the depression contained in the Psychiatric Literature".

Section C

Lazarus Coping Scale :

The modified Lazarus Coping Scale is 30 item test.

SCORING KEY :

Each category purports to describe a specific behavioural manifestation of depression and consists of a graded series of 4 self evaluative statements. The statements are rank ordered and weighted to reflect the range of severity of the symptom from neutral to maximum severity. Numerical values 0, 1, 2, 3 are assigned to each statement to indicate degree of severity. The maximum score is 90.

INTERPRETATION OF THE SCORE :

With respect Beck's Depression Inventory the Scoring was designed as follows:

0-30	<50%	Mild Depression
31-60	50% - 75%	Moderately Depression.
61-90	>75%	Severely Depression.

With respect the modified Lazarus Coping Scale Scores were classified as

Never	-	1
Sometimes	-	2
Always	-	3
Below 50%	-	Inadequate Coping
50% to 75%	-	Moderate Coping
Above 75%	-	Adequate Coping.

VALIDITY OF THE TOOL :

The content of the Research Tool was validated by 3 Psychiatric Nursing Experts Minor suggestions regarding rearrangement and modification of questions were made in the tool. The experts suggestions were incorporated in the tool and it was finalized and used for the main study.

RELIABILITY OF THE TOOL

The Reliability of the tool was obtained by establishing Karl Pearson's Correlation Co-efficient method for both Depression and Coping Strategies and the "r" value was "r"=0.79 for depression inventory and "r"= 0.76 for coping Strategies and the tools was found to be reliable to conduct main study. The scores indicated a high correlation & hence the tool was considered as reliable.

ETHICAL CONSIDERATIONS

Ethical Consideration refers to a system of moral values that is concerned with the degree to which research procedures adhere to professional legal and social obligations to the study participants (polit and hungler, 2001)

The study was conducted only after the approval of Dissertation Committee. Before proceeding the study the formal consent was obtained from Director of We Care Social Service Society, Singaperumal Koil HIV Clients were explained clearly about the study purpose and a verbal consent obtained before interviewing. All information about samples were kept confidential.

PILOT STUDY

According to Polit and Hungler a Pilot study is a small scale version or trial rundown in preparation for major study. The principle focus of a pilot study is to assess the adequacy of the data collection plan. A pilot study should be carried out with as much care as the major study so that any detected weakness will be truly representative of inadequacies inherent in the major study. In this study, the Pilot study was conducted with prior permission from the authorities obtained. Informed consent was obtained from 10 samples,

who were selected according to the sampling method. Data was collected by interviewing and using a questionnaire. Privacy and confidentiality was ensured. The study was found to be feasible in terms of availability of samples, co-operation of the institution, time, distance, money and material.

DATA COLLECTION PROCEDURE :

Data Collection is the gathering of information needed to address the research problem.

The study was done for the specified period of 4 weeks. Official permission was obtained from the Director of WE CARE SOCIAL SERVICE SOCIETY. The 100 patients who fulfilled the selection criteria were selected by convenient sampling. Confidentiality was ensured. The purpose of the study was explained to the patients and the informed consent was obtained from the patients. Depression and Coping Strategies was measured by the self administered questionnaire. The average time taken to collect information from one patient was 30 minutes.

Date	**No. of Samples**
17.05.2010	5
18.05.2010	7
19. 05.2010	5
20. 05.2010	8
21. 05.2010	5
22. 05.2010	5
24. 05.2010	5
25. 05.2010	5
26. 05.2010	7
27. 05.2010	6
28. 05.2010	4
29. 05.2010	5
31. 05.2010	5
01.06.2010	5
02.06.2010	4
03.06.2010	8
04.06.2010	5
05.06.2010	6
TOTAL	**100**

DATA ANALYSIS PROCEDURE:

Both descriptive and inferential Statistics were used.

Descriptive statistics :

Analysis of demographic data of clients was done in terms of frequency and percentage distribution. Mean and standard deviation was used to compute the depression and coping strategies on problems related HIV Clients.

Inferential Statistics :

Correlation Co-efficient was used to study the Correlation between depression and coping with socio demographic variations.

Chi-Square Test was used to associate the depression and Coping strategies with the demographic variable.

Analysis and interpretation of the data are given in the following chapter.

CHAPTER – IV

DATA ANALYSIS AND INTERPRETATION

This chapter deals with the data analysis and interpretation to evaluate the level of depression and coping strategies among HIV infected client.

According to the study objectives the interpretation has been tabulated and organized as follows:

ORGANIZATION OF DATA

Section A : Description of demographic variables

Section B : Assessment of level of depression and coping strategies among HIV infected clients.

Section C : Correlation between level of depression and coping strategies among HIV infected clients.

Section D : Association of level of depression and coping strategies among HIV infected clients with their demographic variables.

SECTION A

Table 1: Frequency and percentage distribution of demographic variables of depression and coping strategies.

N = 100

Demographic Variables	No.	%
Age		
20 – 25	8	8
26 – 30	26	26
31 – 35	33	33
36 – 40	19	19
41 – 45	9	9
46 – 50	5	5
Sex		
Male	63	63
Female	37	37
Education		
Primary education	33	33
Higher secondary	44	44
Graduate	8	8
Illiterate	15	15
Occupation		
Coolie	35	35
Employed	35	35
Housewife	4	4
Others	19	19
Unemployed	7	7
Income		
Rs.1000 – 2000	57	57
Rs.2001 – 3000	41	41
Rs.3001 – 4000	2	2
Above Rs.4000	0	0
Religion		
Hindu	66	66
Muslim	30	30
Christian	4	4
Marital Status		
Married	67	67
Unmarried	8	8
Separated	14	14
Widow	11	11
Children		

Demographic Variables	No.	%
1 Child	18	18
2 Children	52	52
3 Children	17	17
More than 3	9	9
No Children	4	4
Availability of support system		
Relatives	83	83
Agencies	10	10
Social Support	7	7
Others	0	0
Duration of Illness		
0 – 1 year	24	24
1 – 2 years	26	26
2 – 3 years	27	27
3 – 4 years	18	18
More than 4 years	5	5

Table 1 represents the frequency and percentage distribution of demographic variables of depression and coping strategies.

With regard to age, majority 33(33%) of the clients were 31 – 35 yrs, 26(26%) clients were 26 – 30 yrs , 19(19%) clients were 36 – 40, 9(9%) clients were 51 – 45 yrs, 8(8%) clients were 20 – 25 yrs and 5(5%) clients were 46 – 50 yrs.

With regard to sex, 63(63%) clients were male and 37(37%) clients were female.

With regard to education, majority 44(44%) clients were higher secondary, 33(33%) clients were primary education, 15(15%) clients were illiterate and 8(8%) clients were graduates.

With regard to occupation, majority 35(35%) were coolie, 35(35%) clients were employed, 7(7%) clients were unemployed and 4(4%) clients were others.

With regard to income, majority 57(57%) clients were getting Rs.1000 – 2000, 41(41%) clients were getting Rs.2001 – 300, 2(2%) clients were Rs.3001 – 4000 and none of the clients were above Rs.4000.

With regard to religion, majority 66(66%) clients were Hindus, 30(30%) clients were Muslims and 4(4%) clients were Christian.

Regarding marital status, majority 67(67%) clients were married, 14(14%) clients were separated, 11(11%) clients were widow and 8(8%) clients were unmarried.

Regarding children, majority 52(52%) clients were having 2 children, 18(18%) clients were having 1 child, 17(17%) clients were having 3 children, 9(9%) clients were having more than 3 children and 4(4%) clients were having no children.

With regard to availability of support system, majority 83(83%) clients were getting support from relatives, 10(10%) clients were getting support from agencies, 7(7%) clients were getting support from social support and none of the clients were getting others.

With regard to duration of illness, majority 27(27%) of clients were 0 – 1 year, 26(26%) clients were 1 – 2 years, 24(24%) clients were 2 – 3 years, 18(18%) clients were 3 – 4 years and 5(5%) clients were more than 4 years.

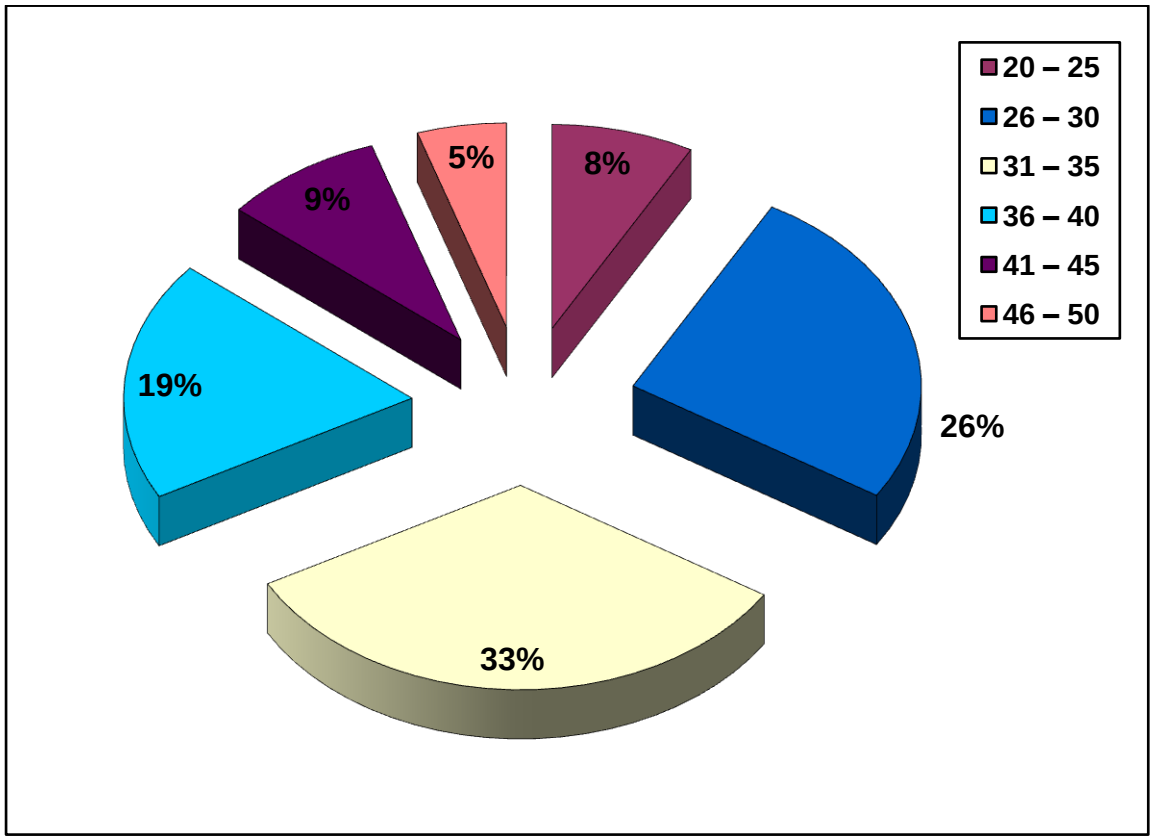


Fig.2: Percentage distribution of age of the clients

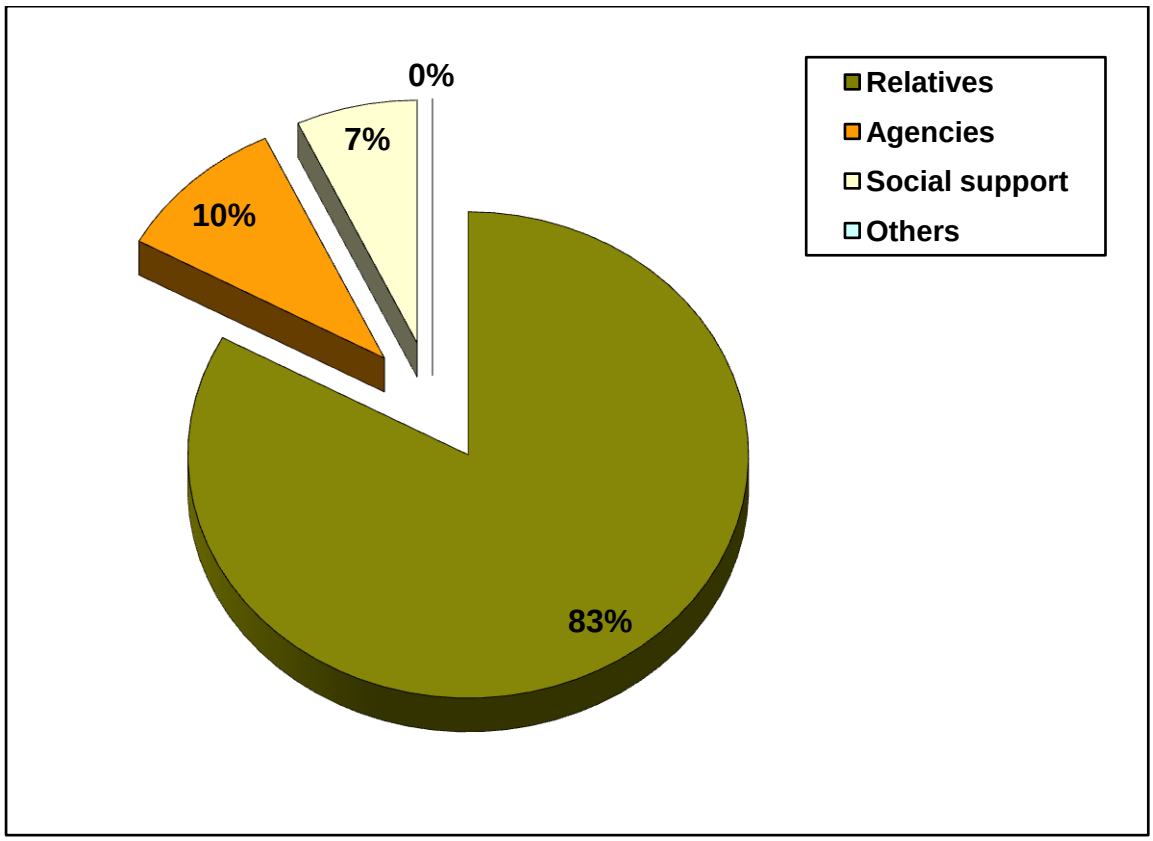


Fig.3: Percentage distribution of availability of support system of the clients

SECTION B

Table 2: Frequency and percentage distribution of level of depression of HIV infected clients.

N = 100

Variable	Mild (<50%)		Moderate (50 – 75%)		Severe (>75%)	
	No.	**%**	**No.**	**%**	**No.**	**%**
Level of Depression	11	11.0	74	74.0	15	15.0

The table 2 reveals that majority 74(74%) clients had moderate level of depression, 15(15%) had severe depression and 11(11%) had mild depression.

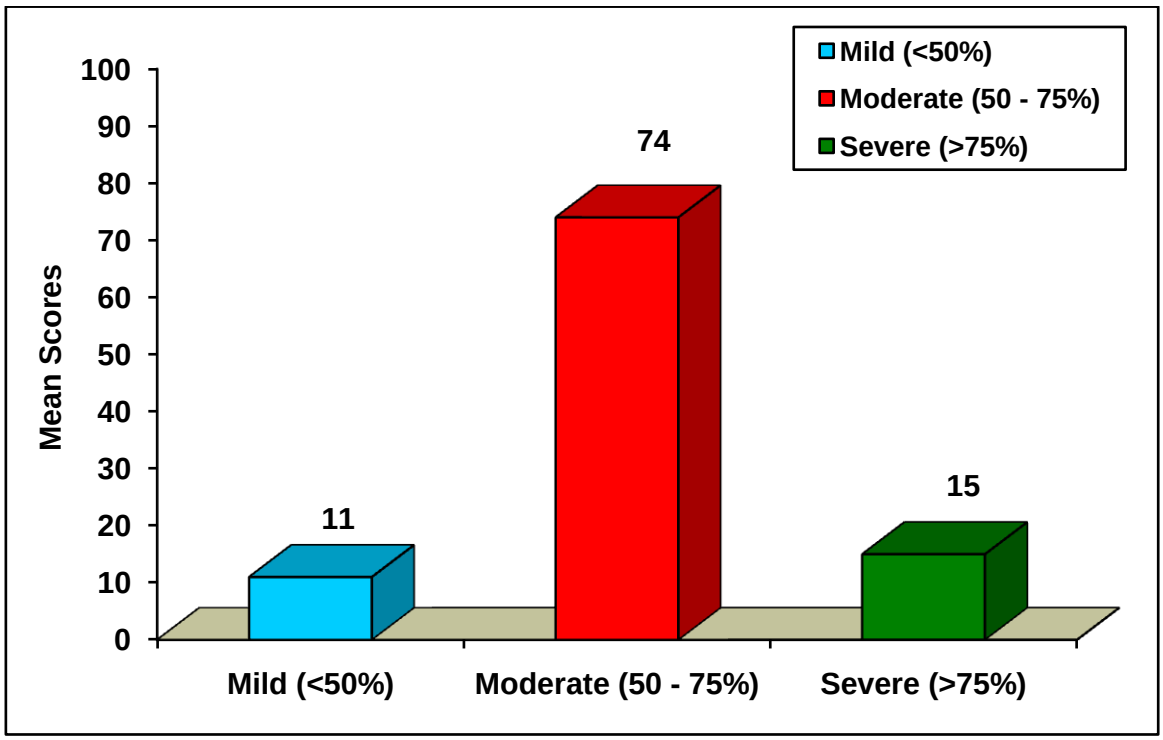


Fig.4: Percentage distribution of level of depression of HIV infected clients.

Table 3: Frequency and percentage distribution of level of coping strategy of HIV infected clients.

N = 100

Variable	Inadequate (<50%)		Moderately Adequate (50 – 75%)		Adequate (>75%)	
	No.	%	No.	%	No.	%
Level of Coping Strategy	7	7.0	90	90.0	3	3.0

The table 3 reveals that majority 90(90%) clients had moderately adequate level of coping strategy, 7(7%) had inadequate level of coping strategy and 3(3%) had adequate level of coping strategy.

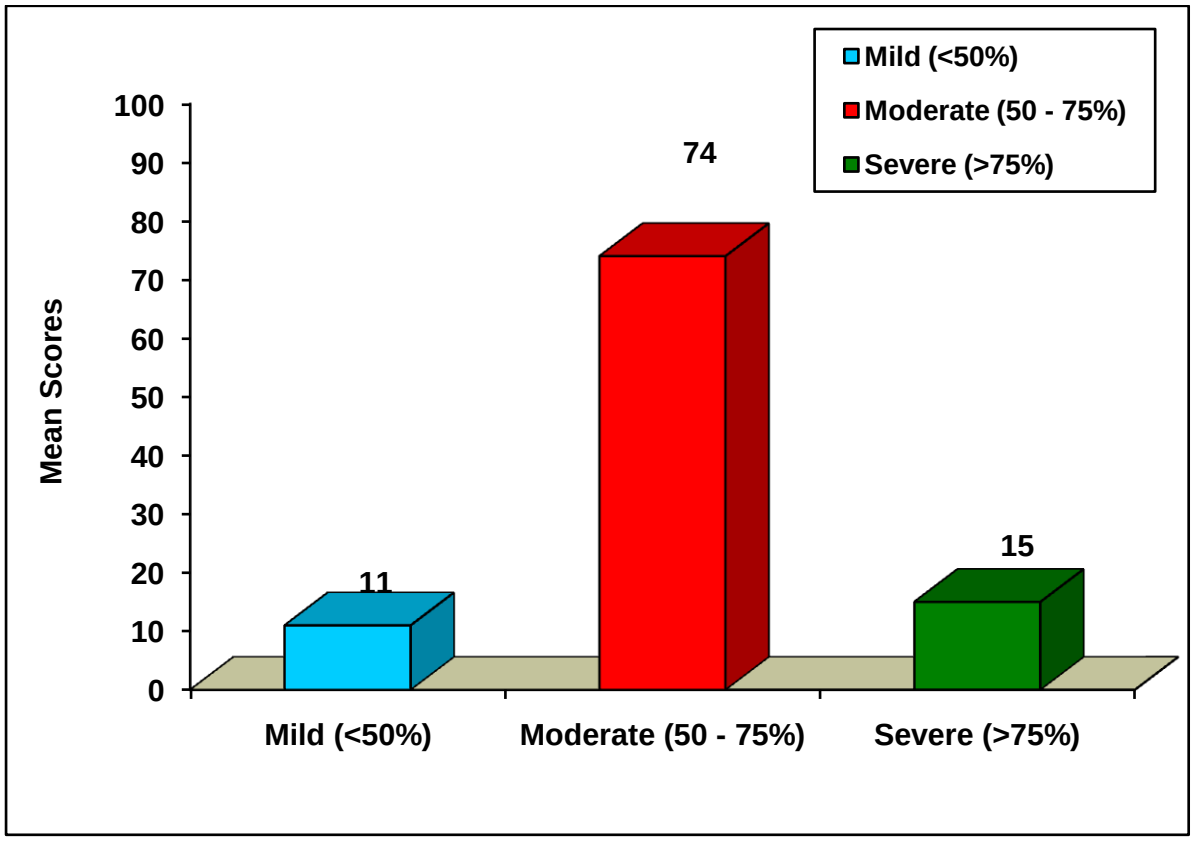


Fig. 5: Percentage distribution of level of coping strategy of HIV infected clients.

SECTION C

Table 4: Correlation between level of depression and level of coping strategy among HIV infected clients

N = 100

Variables	Mean	S.D	'r' Value
Depression	55.83	10.30	0.419**
Coping Strategy	53.63	7.31	(S)

**p<0.01, S - Significant

The table 4 depicts that the mean score of depression was 55.83 with S.D 10.30 and the mean score of coping strategy was 53.63 with S.D 7.31. The calculated 'r' value of 0.419 shows a positive correlation between level of depression and coping strategy and was statistically significant at p<0.01 level.

SECTION D

Table 5: Association of level of depression of the HIV infected clients with demographic variables

N = 100

Demographic Variables	Mild (<50%)		Moderate (50 – 75%)		Severe (>75%)		Chi-Square Value
	No.	%	No.	%	No.	%	
Age							$\chi^2 = 7.08$ d.f = 10 N.S
20 – 25	1	1	5	5	2	2	
26 – 30	2	2	21	21	3	3	
31 – 35	4	4	26	26	3	3	
36 – 40	4	4	11	11	4	4	
41 – 45	0	0	7	7	2	2	
46 – 50	0	0	4	4	1	1	
Sex							$\chi^2 = 4.429$ d.f = 2 N.S
Male	10	10	45	45	8	8	
Female	1	1	29	29	7	7	
Education							$\chi^2 = 2.516$ d.f = 6 N.S
Primary education	5	5	23	23	5	5	
Higher secondary	4	4	35	35	5	5	
Graduate	1	1	5	5	2	2	
Illiterate	1	1	11	11	3	3	
Occupation							$\chi^2 = 12.63$ d.f = 8 N.S
Coolie	6	6	27	27	2	2	
Employed	2	2	25	25	8	8	
Housewife	1	1	3	3	0	0	
Others	1	1	16	16	2	2	
Unemployed	1	1	3	3	3	3	
Income							$\chi^2 = 2.61$ d.f = 4 N.S
Rs.1000 – 2000	6	6	44	44	7	7	
Rs.2001 – 3000	5	5	29	29	7	7	
Rs.3001 – 4000	0	0	1	1	1	1	
Above Rs.4000	0	0	0	0	0	0	
Religion							$\chi^2 = 8.269$ d.f = 4 N.S
Hindu	5	5	49	49	12	12	
Muslim	4	4	23	23	3	3	
Christian	2	2	2	2	0	0	
Marital Status							$\chi^2 = 3.875$ d.f = 6 N.S
Married	7	7	53	53	7	7	
Unmarried	1	1	5	5	2	2	
Separated	2	2	9	9	3	3	
Widow	1	1	7	7	3	3	

Demographic Variables	Mild (<50%)		Moderate (50 – 75%)		Severe (>75%)		Chi-Square Value
	No.	%	No.	%	No.	%	
Children							$\chi^2 = 6.842$ d.f = 8 N.S
1 Child	1	1	15	15	2	2	
2 Children	8	8	36	36	8	8	
3 Children	2	2	14	14	1	1	
More than 3	0	0	6	6	3	3	
No Children	0	0	3	3	1	1	
Availability of support system							$\chi^2 = 29.62$ d.f = 4 S***
Relatives	6	6	68	68	9	9	
Agencies	4	4	5	5	1	1	
Social Support	1	1	1	1	5	5	
Others	0	0	0	0	0	0	
Duration of Illness							$\chi^2 = 17.22$ d.f = 8 S*
0 – 1 year	0	0	11	11	3	3	
1 – 2 years	2	2	15	15	5	5	
2 – 3 years	9	9	31	31	1	1	
3 – 4 years	0	0	14	14	4	4	
More than 4 years	0	0	3	3	2	2	

*p<0.05, ***p<0.001, S – Significant, N.S – Not Significant

The table 5 shows that the demographic variable availability of support system and duration of illness had shown statistically high significant association with the level of depression at p<0.001 and p<0.05 level respectively and the other demographic variable had not shown any statistically significant association with the level of depression.

Table 6: Association of level of coping strategy of the HIV infected clients with demographic variables

N = 100

Demographic Variables	Inadequate (<50%)		Moderately Adequate (50 – 75%)		Adequate (>75%)		Chi-Square Value
	No.	%	No.	%	No.	%	
Age							
20 – 25	1	1	6	6	1	1	
26 – 30	4	4	21	21	1	1	$\chi^2 = 12.78$
31 – 35	1	1	32	32	0	0	d.f = 10
36 – 40	0	0	19	19	0	0	N.S
41 – 45	1	1	7	7	1	1	
46 – 50	0	0	5	5	0	0	
Sex							$\chi^2 = 0.125$
Male	4	4	57	57	2	2	d.f = 2
Female	3	3	33	33	1	1	N.S
Education							
Primary education	3	3	30	30	0	0	$\chi^2 = 4.95$
Higher secondary	3	3	40	40	1	1	d.f = 6
Graduate	0	0	7	7	1	1	N.S
Illiterate	1	1	13	13	1	1	
Occupation							
Coolie	1	1	34	34	0	0	$\chi^2 = 10.01$
Employed	2	2	31	31	2	2	d.f = 8
Housewife	0	0	4	4	0	0	N.S
Others	3	3	16	16	0	0	
Unemployed	1	1	5	5	1	1	
Income							
Rs.1000 – 2000	5	5	52	52	0	0	$\chi^2 = 5.03$
Rs.2001 – 3000	2	2	36	36	3	3	d.f = 4
Rs.3001 – 4000	0	0	2	2	0	0	N.S
Above Rs.4000	0	0	0	0	0	0	
Religion	0	0	0	0	0	0	
Hindu							
Muslim	5	5	58	58	3	3	$\chi^2 = 1.98$
Christian	2	2	28	28	0	0	d.f = 4
Marital Status	0	0	4	4	0	0	N.S
Married	0	0	0	0	0	0	
Unmarried							$\chi^2 = 6.05$
Separated	5	5	61	61	1	1	

Demographic Variables	Inadequate (<50%)		Moderately Adequate (50 – 75%)		Adequate (>75%)		Chi-Square Value
Widow	1	1	6	6	1	1	d.f = 6 N.S
Children	1	1	13	13	0	0	
1 Child	0	0	10	10	1	1	
2 Children							χ^2 = 4.77 d.f = 8 N.S
3 Children	2	2	16	16	0	0	
More than 3	4	4	47	47	1	1	
No Children	1	1	15	15	1	1	
Education	0	0	8	8	1	1	
Primary education	0	0	4	4	0	0	
Always to get help							χ^2 = 6.95 d.f = 4 N.S
Relatives	7	7	75	75	1	1	
Agencies	0	0	9	9	1	1	
Social Support	0	0	6	6	1	1	
Others	0	0	0	0	0	0	
Duration of Illness							χ^2 = 15.6 d.f = 8 S*
0 – 1 year	3	3	10	10	1	1	
1 – 2 years	2	2	20	20	0	0	
2 – 3 years	1	1	40	40	0	0	
3 – 4 years	0	0	16	16	2	2	
More than 4 years	1	1	4	4	0	0	

*p<0.05, S – Significant, N.S – Not Significant

The table 6 shows that duration of illness had shown statistically significant association with level of coping at p<0.05 level and the other demographic variables had not shown any statistically significant association with the level of coping strategy of the HIV infected clients.

CHAPTER V

DISCUSSION

This chapter discuss the finding of the study derived from statistical analysis with its pertinence of the objectives and related literature of the study. The problem stated was a study of assess the level of depression and coping strategies among HIV clients in selected setting.

The objectives of the study were as follows:

1. To assess the level of depression among HIV infected clients.
2. To determine the coping strategies of clients with HIV infection.
3. To correlate the level of depression and coping strategies among the HIV clients.
4. To associate the demographic variables with the level of depression.
5. To associate the demographic variables with the level of coping.

Frequency and percentage distribution of socio-demographic variables were as follows:-

Nearly 33% clients were in age group of 31-35 yrs. With regard to sex 63% clients were male. With regard to education 44% clients were higher secondary. With regard to occupation 35 % clients were coolie. Regarding income 57% clients were getting Rs 1000-2000. With regard to religion 66% clients were Hindus. Regarding marital status 67% clients were married. Regarding Children 52% clients were having 2 children with regard to availability of support system 83% clients were getting support from relative. With to duration of illness 27% of clients were 0-1 year.

The first objective was to assess the level of depression among HIV infected clients :

The analysis revealed that majority 74% clients had moderate level of depression 15% had severe depression and 11% had mild depression.

The result showed that majority of the clients had moderate level of depression.

The second objective was to determine the coping strategies of clients with HIV infection.

The analysis revealed that majority 90% clients had moderately adequate level of coping strategy 7% clients had inadequate level coping strategy and 3% had adequate level of coping strategy.

The result of this study showed that majority of the clients had moderately adequate level of coping.

The third objectives was to correlate the level of depression and coping strategies among the HIV clients.

The data analysis reveled that the correlation coefficient (r= 0.419) Value clearly indicates that there was a positive correlation between level of depression and coping strategy.

The study indicates moderately positive between depression and coping (r= 0.419) which is significant at $p<0.01$ level. Hence the Null Hypothesis Ho1 states that there is no significant relationship between level of depression and level of coping strategies of the HIV Clients was rejected.

The fourth objective was to associate the demographic variables with the level of depression.

The analysis revealed that there was statistically very high significant association of depression with socio demographic variable like availability of support system $\boldsymbol{x}^2$=29.62 and Duration of Illness $\boldsymbol{x}^2$ =24.29 at $p< 0.01$ level.

The analysis revealed that there was no significant association between depression of HIV clients with socio demographic variables like age, sex, education, occupation, income, religion, marital status and children.

This highlights that the depression on HIV clients were influenced by availability of support system and duration of illness.

The fifth objective was to associate the demographic variables with the level of coping

The analysis revealed that there was a significant association of coping strategy of the HIV infected clients with socio demographic variables like duration of illness $x^2 = 5.158$ at $p<0.001$ level.

The analysis revealed that there was no significant association between depression of HIV clients with socio demographic variables like age, sex, education, occupation, income, religion, marital status and children and availability of support system.

This highlights that the depression on HIV clients were influenced by availability of support system and duration of illness.

The conceptional framework was based on modified Penders Health Promotion Model. It has three components which includes modified factors, cognitive factors and likelihood of action.

First component of the model involves the socio-demographic variables and health unit. Second component involves the cognitive factors like assessment of depression and coping strategies on HIV. Third component was likelihood of action, which helped to decrease the depression on HIV Clients. Hence the researches adopted this model and model guided the researches to take likelihood of action, which helps the HIV Clients.

The overall finding of the study showed that the 75% of HIV infected clients had moderated depression and underrleated coping strategy.

The assumption of the study made were

1. Clients may be ignorant about HIV.
2. Clients may know less information about HIV.
3. Adequate information on HIV may promote less depression and adequate coping among HIV infected clients.

The first assumption was that most of the HIV infected clients may be ignorant about HIV infection because the present study proved that 74% of HIV infected clients had moderate depression and 90% of HIV infected clients had moderately adequate coping toward HIV.

CHAPTER VI

SUMMARY, RECOMMENDATIONS, NURSING IMPLICATIONS AND LIMITATIONS.

This chapter presets the summary, nursing implications, recommendations and limitations of the study based on the objectives selected.

SUMMARY:

Researchers studying the prevalence of psychiatric disorders among HIV positive patients have found a 57.3% prevalence of depression among HIV infected patient and a 69.8% prevalence of depression among people co-infected with HIV and hepatitis .

The national survey indicates that its fairly common for HIV physicians to identity depression and similar symptoms in HIV infected patients. A telephone survey of AIDS physicians found that 84.3 % reported that their HIV positive patient suffered from depressive symptoms.

Baseline data on depression was gathered from various groups and communities interviewed by Thranitran. A total number of 75 response were collected using Beck's Depression, inventory and analyzed . It was interesting to note that only 32% of the population falls within normal variation limits. 17% had baseline clinical depression 23% had inadequate depression and 17% of the randomly selected subjects were found to have severe (or) extreme depression atleast at cognitive level.

The objectives of the study were:

1. To assess the level of depression among HIV infected clients.
2. To determine the coping strategies of clients with HIV infection.
3. To correlate the level of depression and coping strategies among the HIV clients.
4. To associate the demographic variables with the level of depression.
5. To associate the demographic variables with the level of coping.

The assumptions of the study were:

1. Clients may be ignorant about HIV.
2. Clients may know less information about HIV.
3. Adequate information on HIV may promote less depression and adequate coping among HIV infected clients.

Extensive review of literature, investigator's professional experience and expert guidance from the field of mental health nursing lead the investigator to design the methodology and to develop the tool for data collection.

The conceptional framework for the study was based on modified Penders health promotion model. The modified frame work portrays that modifying factors and cognitive factors enhances likelyhood of action 1 HIV.

The researcher adopted non-experimental descriptive research approach to assess the level of depression and coping strategies among HIV infected clients.

The study was conducted at We Care Social Service society which was situated in Singapermalkoil, Kancheepuram District.

A non probability convenient sampling technique was adopted by the study and 100 HIV infected clients were selected as the study samples.

With respect to the overall depression a 100 HIV infected clients revealed that 11% of HIV infected clients had mild depression, 15% of HIV infected clients had severe depression and 74% of HIV infected clients had moderated depression.

With respect to the overall coping strategy, 3% of HIV clients had inadequate coping, 7% of HIV clients had adequate coping and 90% of HIV clients had moderately adequate coping.

There was a statistically positive correlation between depression and coping strategies ($r=0.419$) at $P< 0.01$ level hence the null hypothesis Ho1 stated that there is no significant relationship between level of depression and level of coping strategies of the HIV clients was rejected.

A Statistically high significant was found between the level of depression on HIV clients, availability of support system X^2= 29.62, Duration of illness X^2=24.29 significant at P<0.01 level. The association between the level of depression of HIV clients with other socio demographic variables did not show any statistically significant association.

A statistically significant association was found between the coping strategies on HIV clients with variables duration of illness x^2 = 5.518 significant at P<0.01. The association between the coping strategies of HIV infected clients with other socio-demographic variables did not show any statistical significant association.

The study conducted that HIV clients had moderate depression and moderately coping strategies towards HIV.

NURSING IMPLICATIONS

The investigator had derived the following vital implications from the study which are vital concern in the field of nursing practice, nursing administration, nursing education and nursing research.

Nursing Practice

1. In hospital the nurse as a service provider should periodically organize and conduct education programme on HIV infected clients.
2. The nurse must implement information education communication (IEC) to provide awareness to the HIV clients on causes, prevention and control.
3. As a service provider the nurse should provides on (HIV) depression related disorders and distribute to people in the community to improve their knowledge
4. A direct service care providers, identify the practice among different communities to strengthen the health of citizens and HIV clients.
5. Psychiatric nurse who works with the local rehabilitation centers should organize programs or prevention of HIV.

Nursing Education

1. Nurse educator should actively involve in the process of organizing continuing education Program on HIV related disorders (depression) and preventive measures.
2. The nurse should organize symposium, seminars, conferences and workshops to disseminate the current research findings on HIV to the public and to other health professionals.
3. Make available literature related to HIV and depression related disorders as the library for student reference.

Nursing Administration

1. The nurse must be instrumental to pointing out relevant policies of the state and central level of ensure effective programme to educated the public and facilitate optimal allocation for implementation of the programme and create inter sectoral network to control the disorder.
2. The psychiatric nurse as an administrator should design formal teaching for programme on prevention of HIV for community people in the selected community.
3. provide opportunity for nurses to attend training programme.
4. carryout periodically depression related disorders surveillance and produce and updated epidemiological picture.

Nursing Research

1. Encourage further studies on HIV infected clients in different settings.
2. As evident from the review of literature more research need to be conducted on the aspects of HIV depression related disorders.

RECOMMENDATIONS

1. A similar study can be replicated on large sample at state level.
2. A comparative study on HIV can be done between different settings.
3. A similar study can be conducted by using structured teaching programme on HIV.

LIMITATION:

The time allotted for data collection was not sufficient.

REFERENCES

BOOKS

Ahuja Niraj. (2002). *A short textbook of psychiatry* (5th ed.). New Delhi Jaypee Medical Publisher (P) Ltd.,

American Psychiatric Association (2000) *Diagnostic and statistical manual of mental disorders* (4th ed.). Text revision. Washington : American Psychiatric Association.

Barbara Schoen Johnson (1995). *Child adolescent and family psychiatry nursing Philadelphia* : J.B. Lippincott Company.

Basavanthappa B.P. (1998), *Nursing research* (3rd ed), Mumbai : Jaypee Brother Publisher.

Ben Green(1996) *Problem based Psychiatry* (2nd ed.) Edinburgh : Churchill Livingstone Company.

Burne Nancy (2001). *The practice of nursing research*, Philadelphia : W.B. Saunders Company Publisher.

Gail W. Stuart, Michele T. Lararia (2005) Principles *and practice of Psychiatric Nursing* (8th ed). Missouri : Mosby Publication.

John A. Talbott. (1994). *Textbook of Psychiatric Nursing an Indian Perspective,* Bangalore, VMG publication.

Kapalan and Sadock's (1998), *Synopsis of Psychiatry* (8th ed.) New Delhi : New B.L. Waverky Pvt. Ltd.,

Mary C. Townsend, (2006), *Psychiatric Mental Health Nursing* (5th ed.) Philadelphia : F.A. Davis Company Publishers (P) Ltd.,

Polit F. Denise, Hungler P. Bernadette. (2002) *Nursing research principle and methods* (6th ed). Philadelphia : J.B. Lippincott Company.

K. Park (1955), *Social and preventive Medicine* (12th ed). Jaypee Brother Publication Pvt. Ltd.,

Ratherine in. Fortinash, Patricia A. Holoday Worrect (1996). *Psychiatric Mental Health Nursing* (1st ed). New York : Mosby Publications.

Robert E. Hales, Stuart C. Yudossky, John A. Talbott, (2001). *Text book of Psychiatry* (3rd ed). New Delhi : Jaypee Brothers Publications.

Sadock B.J., Sadock V.A. (2005). *Comprehensive textbook of Psychiatry* (8th ed). Philadelphia : Lippincott Williams & Wilkins.

Sreevani R. (2005). *A guide to mental health and Psychiatric Nursing* (2nd ed). New Delhi : Jaypee Brothers Publication.

Sundar Rao P.S., Richard, J. (1996). *An Introduction to biostatistics* (3rd ed). New Delhi: Prentice Hall of India.

Varma K. Vijay (1998) *Social Psychiatry and global perspective*, New Delhi, Rajiv Bai Macmillan India Limited.

Verna Benner Carson (2000). *Mental Health Nursing* (2nd ed). Philadelphia : W.B. Sunders Publications.

Wanda K. Mohr. (2003). *Psychiatric Mental Health Nursing* (5th ed). Philadelphia : Lippincott Publications.

Basavanthappa B.P. (1996). *Community Health Nursing* (4th ed) Mumbai, Jaypee Brothers Publication.

JOURNALS

Anastasi, J.K., & Capili, B. (2006). Symptom Management of *HIV – related diarrhea by using normal foods Nurses AIDS care, 47-57.*

Deepika Cecil Khakha (2006). Caring for carers : missing block in HIV (Aids Care – *Nursing Journal of India,* Vol. 127 (12), 275-276.

Dobe, M. (1995). Awareness an AIDS among health care professionals. *Indian Journal of Public Health,* 105-106.

Gande, S. (2004). *Palliative Care for people with HIV/AIDS.* Health Dialogue, Vol. 36, 5-7.

Harharan P, G. (2004). *Truth of AIDS.* Indian Red Cross Society, 45-50.

Holzener & William, 2. (2003). Symptoms Strategies & information. *American Journal of Nursing,* Vol. 102 (4), 40-53.

Janis Sky. (2005). liberating patient with HIV. *Nursing Times,* Vol. 101(49), 16-18

Jones Martin (2001). Health Promotion priorities of people with HIV. *Nursing Times,* Vol. 97(1), 34-36.

Joseph Jasmine Benny. (2004). Knowledge with held of college student regarding HIV/AIDS. *The Nursing Journal of India,* Vol. 77 (44), 272-274.

Kubele, S.S., Zodpens, S.D., Vasudeo,N.D. (1995). AIDS awareness among nursing students. *Indian Journal of public Health,* 109-112.

Mccarthy G.M. (1999). Returned to treat HIV Infection Patients. *American Journal of Nursing, 8.*

Prabhudeva S.S.(2006) Stop AIDS, heep the promise, *Nightingales Nursing Times, 3.*

Prema Balu M.N. (2003) Antobiography of HIV. *Nightingales Nursing Times, 9-12.*

Stinson (2005) Opportunistic Infection. *National AIDS control Association,* 51-58.

Uhaka Deepika Cecil (2006). Caring for cancer missing block in HIV/AIDS Care. The *Nursing Journal of India,* Vol. 127(12), 275-276.

Uzgane Rajashekar (2006). *AIDS new beginning. Health Screen,* 10-20.

Wert, A.M. (1996). HIV Counselling & Treatment. *Journal of Promotional Nursing,* 225-232.

WEBSITES :

www.pubmed.com

www.findarticles.com

www.webmed.com

www.nursingplanet.com

www.geocities.com

www.wikipedia.org

www.flipkart.com

www.infibeam.com

www.metnalhelp.net

www.tn.gov.in

www.southindia.com

www.naco.com

APPENDIX-A

LIST OF EXPERTS FOR CONTENT VALIDITY

1. **Dr.M.Anand Pratap, M.B.B.S., D.P.M.,**
   Chief Civil Surgeon (Psychiatry) R.M.O.,
   Govt. General Hospital,
   Chennai-600 003.

2. **Mrs. Grace, R.N, R.M., M.Sc(N).,**
   Head of the Department,
   Mental Health Nursing,
   Madha College of Nursing,
   Chennai-600 071.

3. **Mrs. Neelakshi, R.N, R.M., M.Sc (N).,**
   Head of the Department,
   Mental Health Nursing
   Ramachandra College of Nursing,
   Chennai – 600 062.

4. **Mrs. S.O. Margaret, R.N, R.M., M.Sc (N).,**
   Professor & HOD
   Mental Health Nursing
   Dr. Syamala Reddy College of Nursing,
   Marathahalli, Bangalore.

5. **Mrs. M. Fathima Jessy, M.S.W., M.Phil.,**
   Social Welfare Officer,
   Institute of Mental Health,
   Kilpauk, Chennai-600 010.

LETTER SEEKING EXPERTS OPINION FOR CONTENT VALIDITY

From

Mrs. Kalaiselvi .K

M.Sc (Nursing). I year,

Vel.R.S. Medical College – College of Nursing,

Avadi, Chennai-600062.

To

Respected Madam/sir

Sub: Requisition for expert opinion on suggestion for content validity of the tools.

I am Mrs. K. Kalaiselvi, a student of M.Sc (Nursing)- I year at Vel.R.S. Medical College – College of Nursing, Avadi, Chennai-600062,affiliated to Dr. M.G.R Medical University, Chennai.

As a partial fulfillment of the requirement in the M.Sc Nursing programme, I have to complete a dissertation. The topic I have selected is " A study to assess the level of depression and coping strategies among HIV clients in selected setting."

Herewith I am sending the developed tools for content validity and for your expert opinion and valuable suggestions.

Thanking you,

Yours Sincerely

(K. KALAISELVI)

Enclosures:

1. Statement and Objectives of Study
2. Blue Print of the Tools
3. Content Validity Certificate

CERTIFICATE FOR CONTENT VALIDITY

This is to certify that the tools developed by Mrs. Kalaiselvi .K M.Sc Nursing student Vel.R.S Medical College College of Nursing, Chennai on the topic, " A study to assess the level of depression and coping strategies among HIV clients in selected setting." Is validated by the undersigned and she can proceed with this tool to conduct the main study.

Place:

Date: Signature

APPENDIX-B

INTRODUCTION

Dear Participants,

I am K. Kalaiselvi M.Sc (N), II year student from Vel R.S. Medical College – College of Nursing, Avadi, Chennai. I would like to assess the level of depression and coping strategies among the HIV Clients. I assure that the response given by you will be used for my study purpose. There is no right or wrong answers. So please feel free in answering the questions. This will be promoting your welfare. So, I request you to kindly give your full co-operation and willingness.

Thanking you.

Date :

Place :

DEMOGRAPHIC VARIABLES

1.Age in year

a. 20-25
b. 26-30
c. 31-35
d. 36-40
e. 41-45
f. 46-50

2. Sex

a. Male
b. Female

3.Education

a. Primary Education
b. Higher Secondary
c. Graduate
d. illiterate

4.Occupation

a. Colly
b. Employed
c. Unemployed
d. Housewife
e. Others

5.Monthly Income in Rupees

a. 1000-2000
b. 2001-3000
c. 3001-4000
d. Above 4000

6.Religion

a. Hindu
b. Muslim
c. Christian

7.Marital Status

a. Married
b. Single
c. Separated
d. Widow

8.Number of Children

a. 1
b. 2
c. 3
d. More than 3
e. No children

9.Availability of any support system

a. Relatives
b. Agencies
c. Social support
d. Others

10.Duration of illness

a. 0 - 1 year
b. 1 - 2 years
c. 2 - 3 years
d. 3 - 4 years
e. more than 4 years

BECK'S DEPRESSION INVENTORY QUESTIONNAIRE

1. SADNESS
   0 I do not feel sad.
   1 I feel sad much of the time.
   2 I am sad all the time.
   3 I am so sad or unhappy that I cannot.

2. PESSIMISM
   0 I am not discouraged about my future.
   1 I feel more discouraged about my future than I used to be.
   2 I do not expect things to work out for me.
   3 I feel my future is hopeless and will only get worse.

3. PAST FAILURE
   0 I do not feel like a failure.
   1 I have failed more then I should have.
   2 As I look back, I see a lot of failures.
   3 I feel I am a total failure as a person.

4. LOSS OF PLEASURE
   0 I get as much pleasure as I ever did from the things I enjoy.
   1 I don't enjoy things as much as I used to.
   2 I get very little pleasure from things I used to enjoy.
   3 I can't get any pleasure from the things I used to enjoy.

5. GUILTY FEELINGS
   0 I don't feel particularly guilty.
   1 I feel guilty over many things I have done or should have done.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. PUNISHMENT FEELINGS
    0 I don’t feel I am being punished.
    1 I feel I may be punished.
    2 I expect to be punished.
    3 I feel I am being punished.

7. SELF-DISLIKE
    0 I feel the same about myself as ever.
    1 I have lost confidence in myself.
    2 I am disappointed in myself.
    3 I dislike myself.

8. SELF-CRITICALNESS
    0 I don’t criticize or blame myself more than usual.
    1 I am more critical of myself than I used to be.
    2 I criticize myself for all of my faults.
    3 I blame myself for everything bad that happens.

9. SUICIDAL THOUGHTS OR WISHES
    0 I don’t have any thoughts of killing myself.
    1 I have thoughts of killing myself, but I would not carry them out.
    2 I would like to kill myself.
    3 I would kill myself if I had the chance.

10. CRYING
    0 I don’t cry anymore than I used to.
    1 I cry more than I used to.
    2 I cry over every little thing.
    3 I feel like crying, but I can’t.

11. AGITATION

0 I am no more restless or wound up than usual.

1 I feel more restless or wound up than usual.

2 I am so restless or agitated that it's hard to stay still.

3 I am so restless or agitated that I have to keep moving or doing something.

12. LOSS OF INTEREST.

0 I have not lost interest in other people or activities.

1 I am less interested in other people or things than before.

2 I have lost most of my interest in other people or things.

3 It's hard to get interested in anything.

13. INDECISIVENESS

0 I make decisions about as well as ever.

1 I find it more difficult to make decisions than usual.

2 I have much greater difficulty in making decisions than I used to.

3 I have trouble making any decisions.

14. WORTHLESSNESS

0 I do not feel I am worthless.

1 I don't consider myself as worthwhile and useful as I used to.

2 I feel more worthless as compared to other people.

3 I feel utterly worthless.

15. LOSS OF ENERGY

0 I have as much energy as ever.

1 I have less energy than I used to have.

2 I don't have enough energy to do very much.

3 I don't have enough energy to do anything.

16. CHANGES IN SLEEPING PATTERN

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.

1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.

2b I sleep a lot less than usual.

3a I sleep most of the day.

3b I wake up 1-2 hours early and can't get back to sleep.

17. IRRITABILITY

0 I am no more irritable than usual.

1 I am more irritable than usual.

2 I am much more irritable than usual.

3 I am irritable all the time.

18. CHANGES IN APPETITE

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.

1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.

2b My appetite is much greater than usual.

3a I have no appetite at all.

3b I crave food all the time.

19. CONCENTRATION DIFFICULTY

0 I can concentrate as well as ever.

1 I can't concentrate as well as usual.

2 It's hard to keep my mind on anything for very long.

3 I find I can't concentrate on anything.

20. TIREDNESS OR FATIQUE

0 I am no more tired or fatigued than usual.

1 I get more tired or fatigued more easily than usual.

2 I am too tired or fatiqued to do a lot of the things I used to do.

3 I am too tired or fatiqued to do most of the things I used to do.

21. LOSS OF INTEREST IN SEX.

0 I have not noticed any recent change in my interest in sex.

1 I am less interest in sex than I used to be.

2 I am much less interest in sex now

3 I have lost interest in sex completely.

22. IDEAS ABOUT FUTURE

0 I feel I have good future.

1 I have less hope in my future.

2 I don't have good future.

3 I never feel about my future.

23. RELATIONSHIP WITH WIFE

0 I have good relationship with my wife.

1 She is not having good relationship than before.

2 I think she has maintaining distance from me.

3 She has not maintaining good relationship.

24. FINANCIAL PROBLEMS

0 I have enough financial support.

1 I feel reduction in my financial support.

2 I have less support from others.

3 I don't have any financial support.

25. SOCIAL PROBLEMS

0 I have not noticed any social problems.

1 They are not mingle with me as before.

2 I am getting bad commands from others.

3 I have more social problems.

26. DEPRESSION MOOD

0 I don’t feel depression.

1 I feel depressed much of the time.

2 I am depressed all the time.

3 I am so depressed that I can’t stand it.

27. ACTIVITIES

0 I can do all the activities.

1 I feel I have reduction in my activities.

2 I can do it minor activities.

3 I never do it any activities.

28. HEALTH

0 I feel I have good health.

1 I have mild reduction in my weight.

2 I don’t have good health.

3 I never feel health.

29. HELPLESSNESS

0 I do not feel I am helpless.

1 I don’t consider myself as helpless.

2 I feel more helpless as compared to other people.

3 I feel utterly helpless.

30. LACK OF ATTENTION

0 I have good attention span

1 I have less attention then I uses to have

2 I don’t have enough attention to do very much.

3 I don’t have enough attention to do any thing.

SCORES

0-30 The person is mild depressed

31-60 The person is moderately depressed

61-90 The person is severely depressed.

LAZARUS AND HASSLES COPING STRATEGY INSTRUMENT

S.No.	Items	Never	Sometimes	Always
1.	Hope that things will get better			
2.	Actively try to change the situation			
3.	Find out more about the situation. So that you can handle in better			
4.	Think through different ways to handle the situation			
5.	Try to maintain some control over the situation			
6.	Over eat			
7.	Try out different ways of solving the problem.			
8.	Draw on past experience to help you handle the situation.			
9.	Try to find meaning in the situation			
10.	Pray			
11.	Fear of the family members			
12.	Worry			
13.	Seek comfort or help from family or friends			
14.	Set specific goals to help solve the problem.			
15.	Accept the situation as it is			
16.	Seeking loneliness			
17.	Laugh at off, figuring that things could be worse.			
18.	Try to put the problem out of your mind.			
19.	Day dreaming			
20.	Get prepared to expect the worst.			
21.	Talk the problem over with someone who has been in the same type of situation			
22.	Try to change the problem directly (or) indirectly.			
23.	Get mad, curse, swear			
24.	Cry, get depressed			
25.	Go to sleep, figuring that things will look better in the morning.			
26.	Don’t worry about it, everything will probably workout fine.			
27.	Withdraw / Resign yourself to the situation			

28.	Work off tension with physical activity			
29.	To achieve the next best position to consider.			
30.	Takeout your tension on someone or something else.			

Score :

Never	-	1
Sometimes	-	2
Below 50%	-	Inadequate Coping
50% to 75%	-	Moderate Coping
Anpve 75%	-	Adequate Coping

முகவுரை

அனைவருக்கும் வணக்கம்.

என் பெயர் கி. கலைச்செல்வி. நான் வேல்.ஆர்.எஸ். மருத்துவக் கல்லூரி– செவிலியர் கல்லூரியில் இரண்டாம் ஆண்டு முதுநிலை பட்டய படிப்பு பயில்கிறேன். என்னுடைய பட்டய படிப்பில் ஆய்வு மேற்கொள்ள வேண்டியுள்ளதால், ‘‘எய்ட்ஸ் நோயாளிகளின் மன அழுத்தம் மற்றும் சமாளிக்கும் வழிமுறைகளை கண்டறிதல்’’ பற்றி ஆய்வினை நடத்த உள்ளேன். தாங்கள் ஒத்துழைப்பு தருமாறு கேட்டுக் கொள்கிறேன்.

நன்றி.

இடம் :

நாள் :

தகவலாளர்களின் விவரம்

1. வயது வருடங்களில்
   (அ) 20-25
   (ஆ) 26 -30
   (இ) 31-35
   (ஈ) 36-40
   (உ) 41-45
   (ஊ) 46-50

2. பாலினம்
   (அ) ஆண்
   (ஆ) பெண்

3. கல்வி தகுதி
   (அ) தொடக்க கல்வி
   (ஆ) மேல்நிலைகல்வி
   (இ) பட்டதாரி
   (ஈ) படிக்காதவர்

4. தொழில்
   (அ) கூலி
   (ஆ) தனியார் பணி
   (இ) அரசு பணி
   (ஈ) வீட்டுபணி
   (உ) மற்றவை

5. மாத வருமானம்
   (அ) 1000 -2000
   (ஆ) 2001-3000
   (இ) 3001 - 4000
   (ஈ) 4000 க்கு மேல்

6. மதம்
   (அ) இந்து
   (ஆ) கிறிஸ்டின்
   (இ) முஸ்லீம்

7. திருமணவிவரம்

(அ) திருமணமானவர்

(ஆ) திருமணமாகாதவர்

(இ) கணவன் (அ) மனைவியை பிரிந்திருப்பவர்

(ஈ) கணவன் (அ) மனைவியை இழந்தவர்.

8. குழந்தைகளின் எண்ணிக்கை

(அ) 1

(ஆ) 2

(இ) 3

(ஈ) 3க்கு மேல்

(உ) குழந்தைகள் இல்லை.

9. உதவிபெறும் வழிகள்

(அ) சொந்தங்கள்

(ஆ) நிறுவனங்கள்

(இ) தொண்டு நிறுவன உதவி

(ஈ) மற்றவை

10. நோய்வாய்பட்ட ஆண்டுகாலம்

(அ) 0 - 1 வருடம்

(ஆ) 1 - 2 வருடங்கள்

(இ) 2 - 3 வருடங்கள்

(ஈ) 3 - 4 வருடங்கள்

(உ) 4 வருடங்களுக்குமேல்

மன அழுத்தத்தை அறிய அளவிடும் கேள்விகள்

1. **சோகம்**

0 நான் சோகமாக உணர்ந்தது இல்லை
1. பெரும்பாலான நேரங்களில் சோகமாக உணர்ந்திருக்கிறேன்
2. எல்லா நேரங்களிலும் சோகமாக உணர்ந்திருக்கிறேன்
3. மிகவும் சோகமாக உள்ளேன்.

2. **நம்பிக்கை**

0 என் எதிர்காலத்தை பற்றிய நமபிக்கை அதிகமாக உள்ளது
1. என் எதிர்காலத்தை பற்றிய நம்பிக்கையில்லா எண்ணம் அதிகம் உள்ளது
2. எல்லாம் நன்றாக நடக்கும் என்ற எதிர்பார்ப்பு இல்லை
3. என் எதிர்காலம் நம்பிக்கை இல்லா ஒன்று என உணர்கிறேன்

3. **கடந்தகால இழப்புகள்**

0 இழப்பு பற்றிய எண்ணம் இல்லை
1. நிறைய இழப்புகளை சந்தித்திருக்கிறேன்
2 கடந்தகால வாழக்கையை திரும்பிபார்க்கையில் நிறைய இழப்புகளை உணர்கிறேன்
3. மொத்ததில் நான் எல்லாவற்றையும் இழந்ததாக எண்ணுகிறேன்

4. **ஈடுபாடுயின்மை**

0. செய்யும் செயலில் அதிக ஈடுபாட்டுடன் இருக்கிறேன்
1. எப்பொழுதும் உள்ளதைவிட செய்யும் செயலில் குறைந்த ஈடுபாட்டுடன் இருக்கிறேன்
2. செய்யும் செயலில் மிக மிக குறைந்த ஈடுபாட்டுடன் இருக்கிறேன்
3. செய்யும் செயலில் எந்த வித ஈடுபாடும் இல்லாமல் இருக்கிறேன்

5. **குற்ற உணர்வு**

0. குற்ற உணர்வு உள்ளதாக உணரவில்லை
1. நான் செய்த நிறைய காரியங்களில் குற்ற உணர்வு உள்ளதாக உணர்கிறேன்
2. எல்லா நேரங்களிலும் குற்ற உணர்வுடன் எண்ணுகிறேன்
3. எப்பொதும் குற்ற உணர்வுடன் எண்ணுகிறேன்

6. **தண்டனை உணர்வு**

1. தண்டிக்கப்பட்ட உணர்வு இல்லை
2. தண்டிக்கப்படலாம் என உணர்கிறேன்
3. தண்டிக்கப்படுவேன் என எதிர்பார்கிறேன்
4. கட்டாயமாக தண்டிக்கப்படுவேன் என உணர்கிறேன்

7**. தன் விருப்பமில்லாமை**

0. என்னை பற்றி நல்ல எண்ணத்துடன் எப்பொதும் உள்ளேன்
1. என்னை பற்றிய தன்னம்பிக்கையை இழக்கிறேன்
2. என்னையே நான் வெறுக்கிறேன்
3. என்னையே நான் விரும்புவதில்லை

8. **தன் குற்றம்**

0. என்னை நானே குற்றம் கூறி கொள்வதில்லை
1. எப்பொழுதும் உள்ளதைவிட அதிக குற்ற உணர்வுடன் உள்ளதாக எண்ணுகிறேன்
2. என் எல்லா தவறுகளுக்கும் என்னையே நான் குற்றம் கூறி கொள்கிறேன்
3. எல்லாவிதமான கெட்ட நிகழ்வுகளுக்காகவும் என்னை நானே குற்றம் கூறி கொள்கிறேன்

8. தற்கொலை எண்ணங்கள

0. எந்த விதமான தற்கொலை எண்ணமும் இல்லை
1. தற்கொலை எண்ணம் உள்ளது. ஆனால் அதை நான் செய்ததில்லை
2. தற்கொலை செய்து கொள்ள எனக்கு விருப்பம்
3. சந்தர்ப்பம் கிடைத்தால் நான் தற்கொலை செய்து கொள்வேன்

9. **அழுதல்**

0. நான் அளவுக்கு அதிகமாக அழுததில்லை
1. இயல்புக்கு அதிகமாக அழுதிருக்கிறேன்
2. சிறிய காரியங்களுக்காவும் அதிகமாக அழுதிருக்கிறேன்
3. அழுவவேண்டும் போல் உணர்கிறேன் ஆனால் என்னால் முடியவில்லை

11. **பதட்டமின்மை**

0. இயல்பாக இருப்பதை விட பதட்டமுடன் உணர்ந்ததில்லை
1. மிகவும் பதட்டமாக இருப்பதாக உணர்கிறேன்
2. மிக மிக அதிகமான பதட்டத்துடன் உணர்கிறேன்
3. அதிகமான பதட்டத்தினால் ஒரு இடத்தில் இருந்து மற்றொரு இடத்திற்கு செல்கிறேன் (அ) எதையாகிலும் செய்து கொண்டே இருக்கிறேன்

12.**விருப்பமின்மை**

0. மற்றவர்களிடம் மற்றும் வேலைகளில் விருப்பமில்லாமல் இருந்ததில்லை
1. முன்பு இருந்ததை விட குறைந்த அளவு விருப்பத்துடன் மற்றவர்களிடம் உள்ளேன்
2. மற்றவர்களிடம் மற்றும் வேலைகளில் அதிகஅளவு விருப்பமில்லாமல் இருக்கிறேன்
3. எல்லாவற்றிலும் விருப்பம் எற்படுத்திக் கொள்வது கடினமாக உள்ளது

13. **முடிவு எடுத்தல்**

0. எப்பொழுதும் முடிவுகளை நானாகவே எடுப்பேன்
1. எப்பொழுதும் உள்ளதை விட முடிவு எடுப்பதில் கடினமாக உள்ளதாக உணர்கிறேன்
2. முடிவு எடுப்பதில் மிக அதிகமான கடினம் உள்ளதாக உணர்கிறேன்
3. எந்த முடிவு எடுப்பதிலும் மிகவும் கஷ்டமாக உள்ளது

14. **பயனின்மை**

0. நான் பயனில்லாதது போல் நினைத்ததில்லை
1. நான் பயனுள்ளவனாக நினைத்ததில்லை
2. மற்றவர்களுடன் ஒப்பிடும்பொழுது மிகவும் பயனற்றவனாக இருப்பதாக நினைக்கிறேன்
3. மிகவும் பயனற்றவனாக உணர்கிறேன்

15. **சக்தியல்லாமை**

0. நான் எப்பொழுதும் சக்தியுடன் இருக்கிறேன்
1. இயல்பாக இருப்பதை விட குறைந்த அளவு சக்தியுடன் இருக்கிறேன்
2. செயல்களை செய்வதற்குரிய போதுமான அளவு சக்தி என்னிடம் இல்லை
3. எதை செய்வதற்கும் உரிய போதுமான அளவு சக்தி என்னிடம் இல்லை

16.**தூக்கத்தில் ஏற்படும் மாறுதல்கள்**

0. என் தூக்கத்தில் எந்த மாறுதல்கலும் இருப்பதாக நினைக்கவில்லை
1(அ) எப்பொழுதும் விட அதிகநேரம் உறங்குகிறேன்
1(ஆ) எப்பொழுதும் விட குறைந்த நேரம் உறங்குகிறேன்
2(அ) மிக அதிகநேரம் உறங்குகிறேன்
2(ஆ) மிக குறைந்த நேரம் உறங்குகிறேன்
3(அ) நாள் முழுவதும் உறங்கிகொண்டே இருக்கிறேன்
3(ஆ) 1 முதல் 2 மணி நேரங்களுக்கு முன்பாக முழிக்கிறேன் ஆனால் மீண்டும் தூங்க முடியவில்லை

17. **எரிச்சலடைதல்**

0. எப்பொழுதும் உள்ளதைவிட அதிகமாக நான் எரிச்சலடைவதில்லை
1. எப்பொழுதும் உள்ளதைவிட அதிகமாக எரிச்சலடைகிறேன்
2. எப்பொழுதும் உள்ளதைவிட மிக மிக அதிகமாக எரிச்சலடைகிறேன்
3. எந்த நேரமும் எரிச்சலாகவே உள்ளேன்

18. **பசியில் ஏற்படும் மாறுதல்கள்**

0. என் பசியில் எந்தவித மாறுதல்களும் இருப்பதாக உணரவில்லை
1(அ) முன்பைவிட பசி குறைவாக உள்ளது
1(ஆ) முன்பைவிட பசி அதிகமாக உள்ளது
2(அ) முன்பைவிட பசி மிகவும் குறைவாக உள்ளது
2(ஆ) முன்பைவிட பசி மிகவும் அதிகமாக உள்ளது
3(அ) எனக்கு பசி என்பதே இல்லை
3(ஆ) எப்பொழுதம் உணவை கண்டால் எரிச்சலாக உள்ளது

19. **மனதை ஒருநிலைபடுத்துவதில் கடினம்**

0. நான் எப்பொழுதும் மனதை ஒருநிலை படுத்துகிறேன்

1. முன்பைவிட என்னால் மனதை ஒருநிலை படுத்தமுடியவில்லை

2. மனதை ஒரே காரியத்தில் நீண்டநேரம் ஒருநிலை படுத்த கடினமாக உள்ளது

3. எனனால் எந்த காரியத்திலும் மனதை ஒருநிலை படுத்த முடியவில்லை

20. **உடற்சோர்வு**

0. முன்பைவிட எந்தவிதமான உடல் சோர்வுமில்லை

1. முன்பைவிட எளிதாக நான் உடல்சோர்வு அடைகிறேன்

2. எந்தகாரியத்தை செய்வதிலும் மிகவும் சோர்வடைகிறேன்

3. எந்த காரியத்தை செய்வதிலும் மிகவும் அதிகமாக சோர்வடைகிறேன்

21. **உடலுறவில் ஈடபாடுஇல்லாமை**

0. என் உடலுறவில் எந்தவிதமாறுதல்களும் இருப்பதாக உணரவின்லை

1. முன்பைவிட மிக குறைவான அளவு ஈடுபாடு உள்ளது

2. முன்பைவிட மிக குறைவான அளவு ஈடுபாடு உள்ளது

3. உடலுறவில் அறவே விருப்பமில்லை

22. **எதிர்காலம் பற்றிய எண்ணம்**

0. எனக்கு நல்ல எதிர்காலம் உள்ளது

1. எதிர்காலத்தில் நம்பிக்கை குறைவாக உள்ளது

2. எனக்கு நல்ல எதிர் காலம் இல்லை

3. எதிர்காலம் பற்றி அறவே நினைப்பதில்லை

23. **மனைவி மற்றும் கணவருடன் உள்ள உறவு**

0. மனைவி மற்றும் கணவருடன் நல்ல உறவுடன் உள்ளேன்

1. நாங்கள் முன்புபோல நல்ல உறவுடன் இருப்பதில்லை

2. நாங்கள ஒருவரை விட்டு ஒருவர் விலகி இருக்கிறோம்

3. நாங்கள முன்பு போல நல்ல உறவுடன் இல்லை

24. **பணப்பிரச்சனைகள்**

0. எனக்கு போதுமான அளவு பணவசதி உள்ளது

1. என் பணவசதியில் குறைவு ஏற்பட்டுள்ளதாக உணர்கிறேன்

2. எனக்கு மற்றவர்களிடம் இருந்து குறைந்த அளவு பண உதவி கிடைக்கிறது

3. எனக்கு எந்த விதமான பண உதவியுமில்லை

25. **சமுகப் பிரச்சனைகள்**

0. எனக்கு எந்தவிதமான சமுகப் பிரச்சனையும் இருப்பதாக உணரவில்லை
1. முன்புபோல என் சொந்தங்கள் என்னுடன் இணைந்திருப்பதில்லை
2. மற்றவர்களிடம் இருந்து மோசமான விமர்சனங்களை பெறுகிறேன்
3. எனக்கு சமுகப் பிரச்சனை அதிகமாக உள்ளது

26. **மகிழ்ச்சியில்லாத மனநிலை**

0. மன மகிழ்ச்சியில்லாதது போல நினைப்பதில்லை
1. அதிகநேரங்களில் மனமகிழ்ச்சியில்லாதது போல நினைக்கிறேன்
2. எந்தநேரமும் மனமகிழ்ச்சியில்லாதது போல நினைக்கிறேன்
3. மிக அதிகமாக மனமகிழ்ச்சியில்லாதது போல நினைக்கிறேன்

27. **செயல்கள்**

0. நான் எல்லாவிதமான செயல்களையும் செய்ய முடியும்
1. என்னுடைய செயல்களில் குறைவான தன்மை உள்ளதாக உணாகிறேன்
2. என்னால் சிறிய செயல்களை செய்ய முடியும்
3. என்னால் எந்த காரியத்தையும் செய்ய முடியாது

28. **உடற் ஆரோக்கியம்**

0. நான் நல்ல உடற் ஆரோக்கியத்துடன் இருப்பதாக உணர்கிறேன்
1. என் உடற்ஆரோக்கியத்தில் சிறிய அளவு குறைவு ஏற்பட்டுள்ளது
2. எனக்கு நல்ல ஆரோக்கியம் இல்லை
3. நான் நல்ல ஆரோக்கியத்துடன் இல்லை

29. **உதவீயின்மை**

0. நான் உதவியில்லாதது போல உணரவில்லை
1. உதவியில்லாதது போல என்னை நான் நினைத்ததில்லை
2. மற்றவர்களுடன் ஒப்பிடுகையில் நான் மிகவும் உதவியற்றவனாக உள்ளேன்
3. எனக்கு எப்பொழுதும் உதவியில்லை

30. **ஈடுபாடுயின்மை**

0. எனக்கு எல்லா வேலைகளிலும் நல்ல ஈடுபாடு உள்ளது

1. முன்பைவிட எனக்கு குறைவான அளவு ஈடுபாடு உள்ளது
2. எனக்கு போதுமான அளவு ஈடுபாடு இல்லை
3. எதை செய்வதற்கும் எனக்கு போதுமான அளவு ஈடுபாடு இல்லை

மன உளைச்சலை சமாளிக்கும் வழி முறைகள்

வ.எண்	மன உளைச்சல் சமாளிக்கும் வழி முறைகள்	ஒருபோதும் இல்லை	சில சமயங்களில்	எப்பொழுதும்
1.	காரியங்கள் சரியாகிவிடும், சுமாராகிவிடும் என நம்புதல்			
2.	சூழ்நிலையை ஓரளவாவது சமளிக்க முயற்ச்சி செய்தல்			
3.	சூழ் நிலையை திறம்படகையாளும் பொருட்டு அச்சூழ்நிலையை துருவித் துருவி அதிகமாக அறிந்துக்கொள்ள முயலுதல்			
4.	சூழ்நிலையை சமாளிக்க பல வழிகளில் ஆலோசித்தல்			
5.	பிரச்சனைகளை உணர்ச்சி வசப்படாமல் காணல்			
6.	அதிகம் சாப்பிடுதல்,புகைத்தல்			
7.	பிரச்சனையைத் தீர்ப்பதற்கு நல்லவிதமான வழிகளில் முயன்று பார்த்தல்			
8.	சூழ்நிலையைச் சமாளிக்க முன் அனுபவத்தை பயன்படுத்துதல்			
9.	சூழ்நிலையின் உண்மைத் தன்னையை அறிய முயலுதல்			
10.	ஜெபித்தல், கடவுள் மீது நம்பிக்கை வைத்தல்			
11.	குடும்பத்தார் பயப்படுதல்			
12.	விஷணப்படுதல்			
13.	குடும்பத்தார்(அ)நண்பரிடமிருந்து ஆறுதல் (அ) உதவி வரும் என்று நாடுதல்			

14.	பிரச்சனைக்குத் தீர்வுகான குறிப்பிட்ட சில குறிக்கோள்களை வைத்துக் கொள்ளுதல்			
15.	சூழ்நிலையை உள்ளவாரே ஏற்றுக்கொள்ளுதல்			
16.	தனிமையில் இருக்க விரும்புதல்			
17	சூழ்நிலையைக் கண்டு நகைத்தல்,சிரித்தல் காரியங்கள் மோசமாகிவிடும் என்று எண்ணுதல்			
18.	பிரச்சனையை மனதைவிட்டு அப்புறப்புடுத்துதல்			
19.	பகல்கனவு மற்றும் கனவு காணுதல்			
20.	மோசமானதையும் ஏற்க தயராகி கொள்ளுதல்			
21.	இதே மாதிரியான சூழ்நிலையில் உள்ள யாராவது ஒருவரிடம் இந்தப்பிரச்சினையை பற்றி பேசுதல்			
22.	சூழ்நிலையை மாற்றுவதற்கு நேரடியாகவே/ தாமாகவே முயலுதல்			
23.	ஆத்திரமடைதல், சபித்தல், சத்தியம் செய்தல்			
24.	கத்துதல்/ அழுதல்/ சோர்வடைதல்			
25.	காலையில் காரியங்கள் சுமாராகிவிடும் என்று எண்ணி படுக்கைக்கு போகுதல்			
26.	அதைப்பற்றி கவலைப்படாதே/ஏறக்குறைய எல்லாம் நன்றாக நடக்கும்			

27.	சூழ்நிலையில் இருந்து நழுவிக் கொள்ளுதல்/ விலகிக்கொள்ளுதல்			
28.	முன உலைச்சலை சரிவர உழைப்பின் மூலம் போக்கிக்கொள்ளுதல்			
29.	அடுத்தபடியாக அடைக்கூடிய மிகச் சிறந்த நிலைக்காக நிர்ணயம் பண்ணிக்கொள்ளுதல்			
30.	உம்முடைய உலைச்சலை வேறு யார் மீதாவது எந்த பொருள் மீதாவது காட்டுதல்			

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13th May 2010

Mrs.M. Anuradha
Principal
Vel R.S. Medical College (College of Nursing)
Avadi,
Chennai-62

Dear Madam

Sub: Main Study by K.Kalaiselvi - Permission granted
Ref: Your letter dated 10.5.2010

Greetings from WE CARE!

With Reference to your letter, we are pleased to permit Mrs.K.Kalaiselvi, Mental Health Nursing Student of Master Degree Nursing of Your College to do project work on "Level of Depression and Coping Strategies among the HIV infected clients" under our Guidance from 15.5.2010 to 15.6.2010.

We are also permitting you to use our Organization's name in the Dissertation and we will provide necessary attendance during the period of study.

Regards

(A.Antony)
Director

Community Care Centre for PLHIV
D-8, 12th Cross Street, Anna Nagar, Behind Chengalpattu G.H, Chengalpattu-603 001, Kancheepuram District, Tamil Nadu Mob: 9384032000

CERTIFICATE OF ENGLISH EDITING

TO WHOMSOEVER IT MAY CONCERN

This is to certify that the dissertation work **"A study to assess the level of depression and coping strategies among HIV clients in selected setting."** done by **Mrs.K.Kalaiselvi** II year M.Sc (Nursing) student of Vel.R.S Medical College, College of Nursing, Avadi, Chennai, is edited for English Language appropriateness by Mr. E. NEELAKANDAN.

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CERTIFICATE OF TAMIL EDITING

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